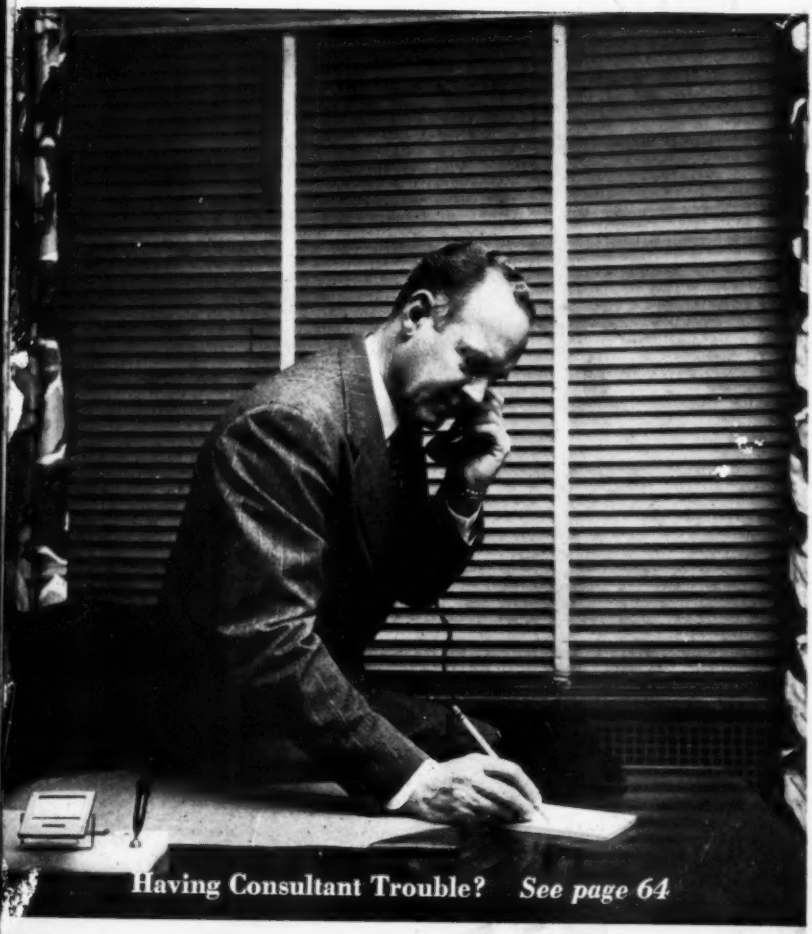
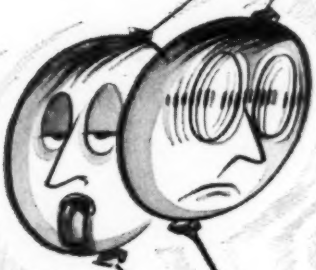
April **Medical Economics**



Having Consultant Trouble? *See page 64*

No belladonna backfire...



blurred vision

dry mouth

when you relieve nervous indigestion with

BENTYL

SAFE, DOUBLE-SPASMOLYSIS

BENTYL Hydrochloride . . . . . 10 mg.
for comfortable relief of nervous indigestion

BENTYL Hydrochloride . . . . . 10 mg.
with PHENOBARBITAL . . . . . 15 mg.
when synergistic sedation is desired

Clinical [1, 2, 3] and pharmacological results show that the dual action of BENTYL (musculotropic, neurotropic) provides complete and more comfortable relief than that of all other antispasmodics tested.

DOSAGE: Two capsules three times daily, before or after meals. If necessary, repeat dose at bedtime.

1. Hock, C. W.: J. Med. Assn. Ga. (*In press*)
2. Hufford, A. R.: J. Mich. St. Med. Soc. 49:1308, 1950
3. Chamberlain, D. T.: Gastroenterology (*In press*)

Trade-mark "Bentyl"

Merrell
1828

New York — CINCINNATI — Toronto

Medical Economics

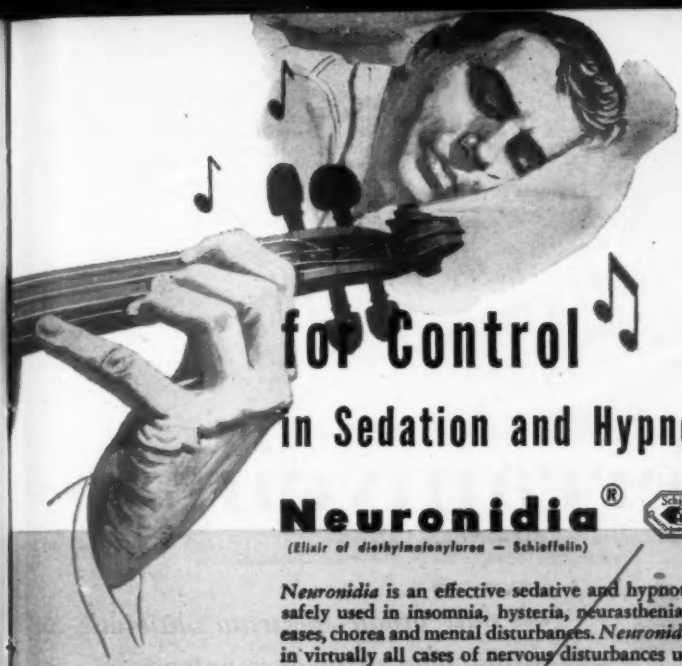
* * * *April 1951* * * *

[CONTINUED ON FOLLOWING PAGE]

Contents [*Continued*]

DEPARTMENTS

CCA MEDICAL ECONOMICS, April 1951 issue, published monthly by Medical Economics, Inc., 210 Orchard Street, East Rutherford, N.J. Copyright 1951. 25c a copy, $3.00 a year (Canada and foreign, $3.50). Acceptance under Section 34.64, PL&R authorized. Circulation: 132,000 physicians and residents. ☆ PICTURE CREDITS: (top to bottom) Cover, 64, 256, Knopf–Pix; 60, Ed Wergeles–Newsweek; 68, Eiger–Black Star; 72, Brown–Rochester Times-Union; 78, Federal Works Agency, Hoffman-Luckhaus, Arrow; 79, Office of Indian Affairs, Modern Hospital, Ewing Galloway; 107, Acme, Strang Memorial Clinic.



for Control

in Sedation and Hypnosis...

Neuronidia®

(Elixir of diethylmalonylurea — Schieffelin)

Neuronidia is an effective sedative and hypnotic. It may be safely used in insomnia, hysteria, neurasthenia, thyroid diseases, chorea and mental disturbances. *Neuronidia* is indicated in virtually all cases of nervous disturbances uncomplicated by pain.

Pharmacological and clinical research have demonstrated that the depth and degree of sedation and hypnosis can be readily controlled with barbital, the active ingredient of

NEURONIDIA

Neuronidia contains per teaspoonful:
0.15 Gm. diethylmalonylurea

Dosage: Orally, as a sedative
½ to 1 teaspoonful repeated as indicated
As a hypnotic
2 teaspoonfuls before retiring

℞ Sodium salicylate ʒIV
Neuronidia ʒIV

Sig: *To induce sleep and produce analgesia*
one dessertspoonful at bedtime.
For sedation and analgesia
One teaspoonful two or three times daily as required.

Supplied: Bottles of 8 fluid ounces, and 1 gallon

Professional samples and literature are available on request.

Schieffelin & Co. since 1794 / *pharmaceutical and research laboratories*
34 Cooper Square, New York 3, N. Y.

NEW high dosage liquid concentrate for greater convenience and flexibility in therapy

CRYSTALLINE

Terramycin

HYDROCHLORIDE

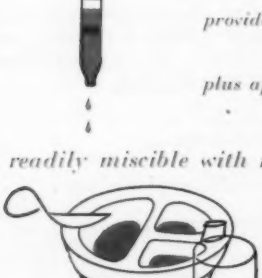
ORAL DROPS

the only broad-spectrum antibiotic available in drop-dose potency

provides: 200 mg. of Crystalline Terramycin Hydrochloride per cc.; approximately 50 mg. in each 9 drops.

plus appeal of attractive cherry color and pleasing cherry-mint flavor.

readily miscible with most foods, milk and fruit juices



affords ease and simplicity of administration and permits a further simplification of dosage schedules in mild and severe infections, and with patients of all age and weight levels.

Available at prescription pharmacies in 10 cc. bottles with specially calibrated dropper.

Antibiotic Division **Pfizer** CHAS. PFIZER & CO., INC., *Brooklyn 6, N. Y.*

1941 • A DECADE OF PROGRESS IN ANTIBIOTIC THERAPY • 1951

Portrait of a former "coughing" patient

after his physician prescribed the highly palatable, non-narcotic Robitussin: distinguished by its intense and prolonged action in increasing respiratory tract fluid, and by its ability to improve mood.

(Glyceryl guaiacolate 100 mg., and desoxyephedrine hydrochloride 1 mg., in each 5 cc.)

Robitussin®

is a product of A. H. ROBINS CO., INC.
RICHMOND 20, VA.
Ethical Pharmaceuticals of Merit since 1878

aid for the ailing

—nutrient tonic and hematinic

Unusually well tolerated and easily assimilated, LIVIBRON helps meet the added vitamin and hematinic requirements of patients in convalescence, in pregnancy, or in the later years.

Combining liver concentrate, ferrous iron, vitamins B_1 and B_2, and manganese, LIVIBRON is useful as adjunctive therapy whenever stress...physiological, surgical, or medical...calls for a nutrient tonic and hematinic. And LIVIBRON's pleasant flavor makes for ready patient acceptance.

Livibron

nutrient hematinic

LIVIBRON: supplied in Liquid and Kapseal form. Each 2 teaspoonfuls (or one Kapseal) represents:

Liver Concentrate equivalent of fresh liver	2.5 Gm.
Vitamin B_1 (Thiamine Hydrochloride)	1.25 mg.
Vitamin B_2 (Riboflavin)	0.5 mg.
Ferrous Sulfate	3.0 gr.
Manganese Citrate	1/16 gr.

PARKE, DAVIS & COMPANY

MEDICAMENTA VERA

Save Money

by using the right tape for the right job

SAVE 40¢, 45¢, 50¢ OR MORE A ROLL WITH NEW

SEAMLESS *service weight* PRO-CAP

Here is a wonderful new lightweight adhesive plaster that can stretch your hard-pressed budget . . . slash your supply expenses—Seamless SERVICE WEIGHT Pro-Cap.

Here is an adhesive plaster *specially made* for those taping jobs that do not require the support of a heavyweight tape. And, because we are able to use a lighter textile fabric, we can pass along big savings to you. This fine new tape meets U.S.P. specifications.

Little or No Skin Irritation—Seamless SERVICE WEIGHT Pro-Cap contains the same exclusive *adhesive mass*—incorporating fatty acid salts—that has made REGULAR Pro-Cap such an outstanding success. Independent clinical tests prove Pro-Cap causes little or no skin irritation, minimizes itching, sticks better, leaves almost no slimy deposit.

Order Seamless SERVICE WEIGHT Pro-Cap today through your Hospital or Surgical Supply Dealer. *Use the right tape for the right job—and save money!*

For Strong Support

REGULAR Pro-Cap in the brown and buff tube. For bandaging, taping and strapping those portions of the body and limbs that require the strong support of a heavyweight tape with high tensile strength.

For Light Taping Jo

SERVICE WEIGHT Pro-C
In the blue and white t
Ideal for bandaging
taping where strongest
port is not necessary.
lighter fabric means
patient comfort, too.

In the New Blue and White Tub

FINEST QUALITY SINCE 1877

SURGICAL DRESSINGS DIVISION

THE SEAMLESS RUBBER COMPANY

NEW HAVEN 9, CONN., U. S. A.

Panorama

Kiss-and-make-up note: In after-dinner speech, President Truman laments that he'd like to know how to win doctors back as political friends. Who'll tell him? . . . New medical journal called Antibiotics and Chemotherapy, to appear in English and Spanish, is edited by staff that includes five Nobel Prize-winners . . . Occupancy of New York municipal hospitals sagged last year, but you'd scarcely notice it. Occupancy rate went from 100.9 per cent to 99.5 per cent.

Methuselah of St. Louis practitioners, Dr. William A. Fries, refused on ethical grounds to pose for news photographs on birthday, was finally persuaded by argument that 90-year-oldster could hardly be accused of advertising to build practice . . . Health insurance getting down on farms through American Farm Bureau Federation, which offers coverage to members in thirty-six states . . . Home accidents to children inspired Children's Hospital, Boston, to issue top-notch booklet of what-to-do directions in case of burns, bites, fractures, and such. Handbook is designed to hang in home beside phone, with physician's number on it.

L. Ron Hubbard, whose best-seller "Dianetics" tells people how to treat their anxieties through his "new science of the mind," now has a worry of his own. State Board of Medical Examiners is cracking down on his dianetics therapy training headquarters in New Jersey on charge of operating medical school without license . . . Another city, Washington, D.C., now lets commercial hospitalization insurance companies pay hospitals directly instead of reimbursing policyholders after bills are paid. Twenty-one D.C. hospitals and twenty-eight group insurance companies have signed agree-

we have crystallized the issue

...with the double-salt Calpurate. The xanthine component of Calpurate is released gradually...all to the good of cardiac patients who require trouble-free, prolonged therapy.

There is little or no gastric irritation with Calpurate. Special coatings, as are necessary with preparations containing highly soluble theobromine salts to obviate gastric upsets, are not needed with Calpurate.

Digitalis may be given simultaneously with Calpurate, as there is no synergistic relationship between the calcium ion and the digitalis glycoside.

Calpurate does not contain the sodium ion.

in cardiac decompensation

whether edema is present or not, rapid improvement follows the myocardial stimulation with Calpurate.

in coronary disease

Calpurate, affording sustained coronary dilation, is a valuable aid in reducing the frequency and the severity of angina pectoris attacks. In thrombosis, when blood supply is equal to increased vigor of contraction, routine use of Calpurate augments blood supply and allays cardiac failure.

in hypertension

Calpurate with Phenobarbital relieves stress, improves circulatory efficiency, and has a desirable sedative effect.

Calpurate (7½ gr.) tablets
Theobromine Calcium Gluconate, Maltbie

Calpurate (7½ gr.) with Phenobarbital (¼ gr.)

The double salt with the triple use

Maltbie Laboratories, Inc., Newark 1, New Jersey

ments . . . Medical indigents in rural areas must often spend dollar or two to get to free clinic, thus defeating clinic's purpose, says Dr. Benjamin Broselow, Clayton, N.J. To bring treatment closer to patient, and to spare him clinic atmosphere, Dr. B. has set aside two hours weekly at his office where indigents can now get medical care gratis.

Apt award: Dr. William P. McKelway, voted outstanding house staffer at George Washington University Hospital, won two-week sightseeing trip to Mayo Clinic . . . Veterans now using V.A. medical facilities more than ever. Agency reports 577,715 hospital admissions last year and nearly 2½ million out-patient examinations, highest in V.A. history . . . Sign of the times: Dr. Elmer T. McGroder, president of Erie County, N.Y., medical society, promises to play up medical economics at all possible meetings. Aim: to boost attendance.

If it's National Health Service or nothing, they'll take nothing, say Drs. Margaret Reynolds and Constance Myatt of Wolverhampton, England. Quitting medical practice, they blame "'bad medicine." Sample gripe: having to prescribe only what's on list of officially approved items, instead of what they think patient needs . . . Bottled-in-bond plasma coming? U.S. whiskey distillers now readying synthetic plasma for possible atomic casualties . . . Bee put on industry to ante up $5 million in drive to finance research on common cold. Backing campaign are American College of Chest Physicians and American Association of Industrial Physicians and Surgeons . . . British medical journal, The Lancet, while admitting that nationalized medicine is overcrowding hospitals denies that this is harming medical standards.

Radio addicts in sixth, seventh, and eighth grades being urged to tune in medical-society-sponsored thriller, "Dr. Tim, Detective," via handsome brochures distributed in twelve Colorado cities . . . Stay-Put Day for military M.D.'s coming July 9, after which medical officers (including reservists) may not request transfer from one military service

What about
premenstrual tension?

How many of your patients
give evidence
of heightened tissue-turgor
with fluid retention
in premenstrual period?

How many of these
patients suffer
from headache, nausea,
backache, nervousness,
malaise or abdominal
distention?

The symptoms of the premenstrual state can now be controlled safely and quickly...

—combines in each tablet 50 mg. of N,N-Dimethyl-N'-(2-pyridyl)-N'-(p-methoxybenzyl) ethylenediamine 8-bromotheophyllinate *[pyrabrom]*—with 100 mg. of acetophenetidin, the dependable, safe analgesic. M-MINUS 4 has evidenced dramatic effectiveness in clinical studies. Patients taking M-MINUS 4 have experienced relief of all symptoms in a very short time. There is good evidence that the administration of M-MINUS 4 has prevented the accumulation of abnormal amounts of fluid in the tissues.

Dosage—One tablet three times a day for three to five days before onset of menses. *Bottles of 24 and 100 tablets.*

Literature and a prescription package of 24 tablets will be sent upon request.

Whittier
LABORATORIES
DIVISION NUTRITION RESEARCH LABORATORIES, INC.
CHICAGO 11, ILLINOIS

to another . . . Small hospitals still finding it tough to get American College of Surgeons approval. Of those with less than fifty beds surveyed last year, only 43 per cent were approved. For hospitals with more than 100 beds, the approval rate was 95 per cent.

Model for white-coated doctor on Norman Rockwell's 1951 Red Cross campaign poster is real-life physician, Dr. James P. Hammond of Bennington, Vt. . . . Scared-cats among medical men let research go to the dogs while cringing before antivivisectionists, fumes A. J. ("Ajax") Carlson, head of National Society for Medical Research. He's incensed by "intellectual cowardice" of one county medical society that refused to support vivisection publicly until a hundred other local groups had come out for it . . . Public relations program must educate people to the good things in medicine, says Dr. Robert H. Baker of Pontiac, Mich., but with more emphasis on facts. Too much current propaganda is mere camouflage, he says—"like the bustle designed to cover stern reality."

Raised-eyebrow dept: Brassieres and girdles called uplifting to health of American womanhood by 84 per cent of doctors, nurses, and personnel directors surveyed by corset and brassiere associations . . . Preview of civilian hospitals' wartime troubles—*e.g.*, fewer nurses, heavier work loads—already seen in New York City hospitals, where around 100 per cent of beds, but only 57 per cent of nursing positions, are filled . . . Blood money: Government contributing about one-third of expected $2 million fund for this year's stepped-up research in ways to collect and preserve whole blood and fractions.

Gambling on averages, Dr. David Edwards of East Hampton, N.Y., has standing offer of $1,000 to parents of first triplets he delivers. In fifty years of practice, he hasn't had to pay off once . . . With only 3,000 Negro M.D.'s for 15 million colored patients, U.S. Negro hospitals are turning more and more to interracial staffing—even in Deep South. Latest example is new 105-bed hospital in Tallahassee, Fla.

sulfa-sugracillin

Sulfa-Sugracillin* flavored granules provide in a palatable form penicillin-sulfonamide combination for enhanced antibacterial action against a wide range of susceptible organisms. The presence of triple sulfonamides, minimizing the danger of crystalluria or renal damage associated with single sulfonamide therapy, affords another desirable feature in this new Upjohn preparation.

Supplied in 60 cc. bottles, containing 1,200,000 units Buffered Penicillin Powder with 3 Gm. Sulfonamides, for the preparation of a pleasantly flavored suspension, providing in each 5 cc. (one teaspoonful) 100,000 units penicillin G potassium and 0.25 Gm. total sulfonamides, comprising equal amounts of sulfadiazine, sulfamerazine, and sulfamethazine.

*Trademark

Upjohn *Medicine . . . Produced with care . . . Designed for health*

THE UPJOHN COMPANY · KALAMAZOO 99 · MICHIGAN

Through the Menstrual Years of Life . . .

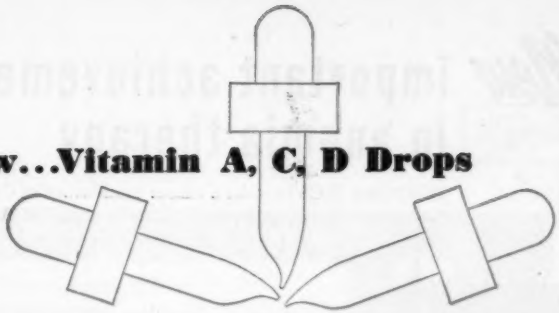
THE frequency with which the menstrual life of so many women is marred by functional aberrations that pass the borderline of physiologic limits, emphasizes the importance of an effective uterine tonic and regulator in the practicing physician's armamentarium.

In ERGOAPIOL (Smith) with SAVIN the action of all the alkaloids of ergot (prepared by hydro-alcoholic extraction) is synergistically enhanced by the presence of apiol and oil of savin. Its sustained tonic action on the uterus provides welcome relief by helping to induce local hyperemia, stimulating smooth, rhythmic uterine contractions and serving as a potent hemostatic agent to control excessive bleeding.

May we send you a copy of the booklet "Menstrual Disorders", available with our compliments to physicians on request.

MARTIN H. SMITH COMPANY
150 LAFAYETTE STREET, NEW YORK 13, N. Y.

Now...Vitamin A, C, D Drops



in aqueous solution for ***better absorption***

Aquasperse

Vitamin ACD Drops

Advantages:

Aqueous Solution — means faster and more efficient absorption of the fat-soluble vitamins A and D.

In conditions in which fat absorption is impaired, such as diarrheas, celiac disease, hepatic and biliary disturbances, the value of an aqueous solution is obvious.

Hypoallergenic — all the component vitamins of Aquasperse are synthetic. Consequently it may be used where patients cannot tolerate natural source vitamins.

Pleasant flavor... no objectionable odor — Aquasperse has an appealing, slightly citrus flavor and practically no odor.

EACH 0.6 CC. CONTAINS:

vitamin A	5000 U.S.P. Units
vitamin D_3	1000 U.S.P. Units
ascorbic acid	50 mg.

Note: The vitamin D_3, in Aquasperse is chemically indentical and biologically equivalent to the vitamin D of cod liver oil.

•

Available—In bottles of 15 cc. and 50 cc. (with calibrated dropper)

WHITE LABORATORIES, INC., Pharmaceutical Manufacturers, Newark 7, N. J.

a *New* important achievement in anemia therapy

HEPTUNA PLUS provides a unique combination of the many factors now known to be essential to hemopoietic efficiency.

VITAMIN B_{12} AND FOLIC ACID — for effective stimulation of the hemopoietic tissues to greater production of red blood cells.

FERROUS SULFATE, COPPER, ZINC, AND COBALT — for rapid and dependable hemoglobin regeneration.

OTHER MINERALS AND VITAMINS — for maintenance of efficient enzyme functioning vital to blood formation and correction of nutritional deficiencies which complicate the anemia syndrome.

For *true* hemopoietic therapy in all anemias, specify.....

Heptuna plus

Each Capsule Contains

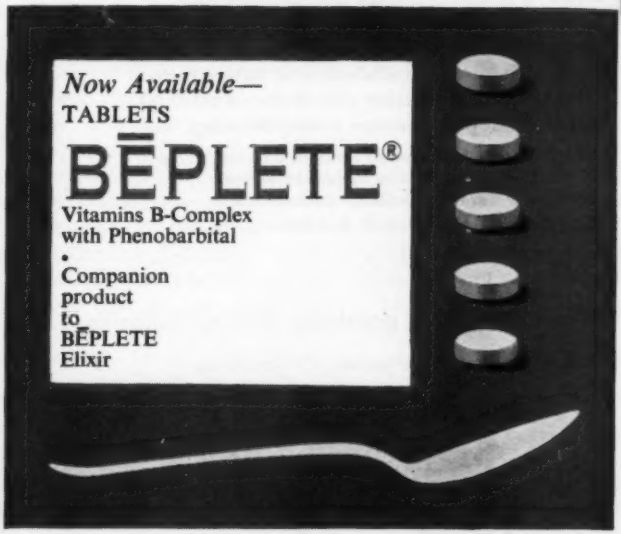
Ferrous Sulfate U.S.P.	4.5 gr.
Vitamin B_{12}*	2 mcg.
Folic Acid	0.85 mg.
Cobalt (Cobaltous Sulfate)	0.1 mg.
Copper (Cupric Sulfate)	1 mg.
Molybdenum (Sodium Molybdate)	0.2 mg.
Boron (Sodium Metaborate)	0.07 mg.
Calcium (Dicalcium Phosphate)	66 mg.
Iodine (Potassium Iodide)	0.05 mg.
Manganese (Manganous Sulfate)	0.033 mg.
Magnesium (Magnesium Sulfate)	2 mg.
Phosphorus (Dicalcium Phosphate)	51 mg.
Potassium (Potassium Sulfate)	1.7 mg.
Zinc (Zinc Sulfate)	0.4 mg.
Vitamin A (Fish Liver Oil)	5000 U.S.P. Units
Vitamin D (Tuna Liver Oil)	500 U.S.P. Units
Vitamin B_1 (Thiamine Hydrochloride)	2 mg.
Vitamin B_2 (Riboflavin)	2 mg.
Vitamin B_6 (Pyridoxine Hydrochloride)	0.1 mg.
Niacinamide	10 mg.
Calcium Pantothenate	0.33 mg.

With other B-Complex Factors from Liver.

*An oral concentrate assayed microbiologically.

J. B. ROERIG AND COMPANY • 536 Lake Shore Dr., Chicago 11, Illinois

Wyeth®



One Tablet corresponds to one Teaspoonful (4 cc.)

Thus, the physician can select the form of medication best suited to his purpose —the delicious elixir, or the handy-to-carry tablets.

In nervousness and fatigue, a judicious combination of low dosage sedation and high dosage B-complex therapy often provides gratifying relief. BĒPLETE supplies both adjuncts, including vitamin B_{12}.

WYETH INCORPORATED
Philadelphia 2, Pa.

Speaking Frankly

Spurned

In a recent issue you mentioned that the North Carolina medical society might ask the state health board to refuse Federal money for public health work. In view of this, it may interest you to know of a recent action of the Hospital Advisory Council of Texas.

For three years our hospital construction program operated on an annual Federal appropriation of $75 million a year. This amount was increased to $150 million but later reduced to $75 million again by the Bureau of the Budget.

The hospital advisory council not only went on record as approving this cut (because of the huge national debt and the tremendous defense expense) but also recommended that the present amount be not increased.

R. W. Kimbro, M.D.
Cleburne, Texas

Jumbos

We note [January Panorama] that New York's United Medical Service now has 2 million subscribers and pays doctors $1 million a month.

Michigan Medical Service had 2,057,679 subscribers as long ago as October 31 last year and our payments to doctors are running about a million and a quarter a month. In fact, we were the first plan to have a million subscribers and the first to have two million.

From now on, of course, we cannot expect to keep up with the United Medical Service, as the companion hospital plan in New York has over 4 million subscribers whereas Michigan Hospital Service has 2,250,000.

L. G. Goodrich, Ass't. Director
Michigan Medical Service
Detroit

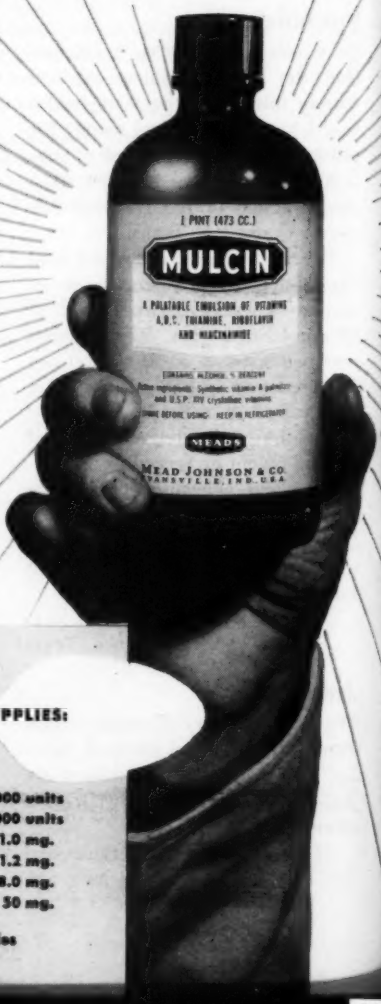
Pathologists

I would like to comment on the explanation you report [January Newsvane] as to why a shortage of pathologists exists.

Your news item suggests, among other things, that the financial reward may not be very inviting. It would seem to me that the opposite is fast becoming true. Since there is a notorious shortage of pathologists, and since every community needs their services, the pathologist should be able to write his own ticket. If not, he can easily change his location, since the shortage in this regard works to his advantage. [*Turn page*]

Mead Johnson & Company presents

An achievement in



EACH TEASPOON OF MULCIN SUPPLIES:

Vitamin A	3000 units
Vitamin D	1000 units
Thiamine	1.0 mg.
Riboflavin	1.2 mg.
Niacinamide	8.0 mg.
Ascorbic Acid	30 mg.

Available in 4 oz. and 16 oz. bottles

in pharmaceutical elegance

MULCIN

6 essential vitamins
in a water-dispersible emulsion
of unexcelled flavor
and physical qualities

Refreshing orange flavor, neither too sweet nor too sour, and a texture of remarkable smoothness make Mulcin a vitamin supplement *pleasing to patients.*

It is light and non-sticky, and flows readily from bottle to spoon.

Children, adolescents and adults enjoy taking Mulcin directly from the spoon. For infants, the dose may be mixed with formula, fruit juice or water.

Ingredients of quality, skilled formulation and meticulous manufacturing controls are combined in Mulcin to make this pleasant, palatable, versatile emulsion a product of pharmaceutical elegance and a distinguished new member of Mead's vitamin family.

MEAD'S

MEAD JOHNSON & CO.
EVANSVILLE 21, IND., U.S.A.

I would like also to mention some advantages not found in the usual clinical specialties:

The pathologist is free of the triflings that plague his clinical colleagues in the form of imaginary complaints. He gains a more intimate knowledge of interesting cases than any other specialist does, and he has an opportunity to pass this information along at medical staff meetings and in his education of internes. Also, since he works more directly with physicians than with the laity, he gets less blame for deeds over which he has no control, and is more likely to receive commendation for work well done.

Frank H. Tanner, M.D.
Lincoln, Neb.

Superfluous

The day I read Dr. Keating's article "Too Many Laboratory Tests?" the following request—believe it or not —was received in the hospital laboratory where I work:

A doctor asked for determination of the Rh factor in a patient who expected her sixteenth baby.

This patient, by the way, was taken care of by the city welfare department, which paid for the medical care.

R.T., Massachusetts

Insecure

Don't let your monthly serve as a sounding board for the antediluvian views of John T. Flynn! The archaic political institutions which Mr. Flynn would like to see rein-

When a physician, writing on the subject of sprains,* advises *"a compression bandage, preferably ACE elastic"*, he indicates the preference of physicians generally.

With ACE Cotton No. 1, all cotton elastic bandage, **ACE Reinforced No. 8,** cotton elastic bandage reinforced with rubber, and **ACE No. 10 Adhesive Elastic Bandage,** cotton elastic bandage with adhesive backing, the physician can obtain varying degrees of compression or support to meet the requirements of each individual patient.

B-D PRODUCTS
Made for the Profession since 1897

*Prognosis on Sprains: Insurance Medicine, June-July-August, 1949, Page 17.

BECTON, DICKINSON AND COMPANY, RUTHERFORD, N. J.

stituted were considered revolutionary in the seventeenth century. In fact, he can best be understood as a dangerous seventeenth-century radical!

His easy disdain for "physical security" is not shared by those who are insecure. Nor, I hope, is it shared by physicians, who above all others appreciate the importance of security.

Doctors, beware of the company you keep!

R. De Young, M.D.
Galveston, Texas

Reminder

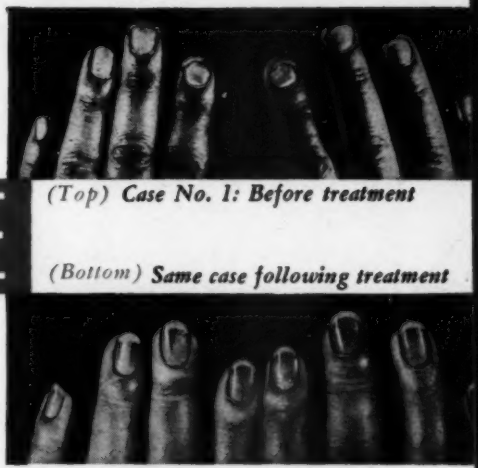
I read with interest Dr. William MacDonald's article, "Let Your Files Remind You." I believe I have a much simpler device for serving the same purpose.

My secretary has on her desk a case (see cut) containing 365 heavy 2½" x 3" cardboard cards, one for every day of the year. These cards bear the month and day (*e.g.*, November 20), the year omitted, thus making the calendar perpetual.

Every morning the first card, which bears yesterday's date, is put at the end, so it will appear again after 365 days. A note written on a 2" x 3" slip of paper put in front of the pertinent date will remind the secretary of the action to be taken on that day.

Mr. Nelson Smith, for instance, should be reminded of his regular physical once a year. When he leaves my office on March 20, my secretary will place in front of

here's help for FRAGILE FINGER NAILS!



(Top) ***Case No. 1: Before treatment***

(Bottom) ***Same case following treatment***

A preliminary report of a recent clinical study[1] on 12 patients complaining of soft, peeling, easily broken finger nails, confirms the value of gelatine in treatment of such conditions. The cases involved were of 1 to 15 years' duration, unyielding to various forms of local therapy.

Each patient was given 7 gms. (1 envelope) of Knox Gelatine daily, dissolved in water or fruit juice. Completely normal appearance of nails in ten cases, is reported in 13 weeks.

Knox Gelatine U.S.P. is 85% pure protein. Easily taken. Easily digested. Most economical. A valuable dietary aid in many conditions.

Available at grocery stores in convenient 4-envelope and 32-envelope economy size packages.

THE EFFECT OF GELATINE ON FRAGILE FINGER NAILS, a brochure indicating the ever-expanding usefulness of Knox Gelatine in certain dietary deficiency conditions is yours free on request. Write KNOX GELATINE, Dept. ME, Johnstown, N. Y.

1. Tyson, T.L., M.D.; *Jl. Inves. Derm.; 14. No. 5 May 1950.*

KNOX
Gelatine U.S.P.

Spasmolysis at its Best . . . by

LIVING TEST

Intubation studies[1,2,3] increasingly confirm the findings of controlled clinical tests and broad professional experience; they dramatically demonstrate the *marked superiority of natural belladonna alkaloids* over the synthetics in relieving smooth muscle spasm.[2,3]

Donnatal employs precise proportions of the principal alkaloids of belladonna, together with a minimal phenobarbital dosage, to intensify the belladonna effects and help correct emotional factors contributing to the provocation of spasm.

REFERENCES: 1. Chapman, W. P., Rowlands, E. N., and Jones, C. M.: New England J. Med., 243:1, 1950. 2. Kramer, P. and Ingelfinger, F. J.: Med. Clin. North America, 32:1227, 1948. 3. Posey, E. L., Bargen, J. A., and Dearing, W. H.: Gastroenterol., 11:344, 1948.

FORMULA: Each tablet, each capsule, and each 5 cc. (1 teaspoonful) of Elixir, contains 0.1037 mg. hyoscyamine sulfate, 0.0194 mg. atropine sulfate, 0.0065 mg. hyoscine hydrobromide, and 16.2 mg. (¼ gr.) phenobarbital.

A. H. ROBINS CO., INC., RICHMOND 20, VA.

Donnatal®

Robins

TABLETS • CAPSULES • ELIXIR

WHENEVER and WHEREVER spasm of smooth muscle causes pain or dysfunction

First aid for the "digestive casualty"

Entozyme greatly simplifies a broad therapeutic approach to many often complex disturbances of the gastro-intestinal tract, through its provision of potent amounts of the principal digestive enzymes: pepsin, pancreatin (with its lipase, amylase, and trypsin), and bile. Its special "tablet-within-a-tablet" construction controls the release of each essential digestive enzyme at its own appropriate gastro-enteric level... in its optimal state of enzymatic activity. This unique action explains the relief gratifyingly elicited in so many cases of pathologic or functional impairment of the digestive process.[1,2,3]

REFERENCES: 1. Kammandel, H. et al.: Bull. N. Y. Med. Coll., Flower & Fifth Ave. Hosps. (in press). 2. McGavack, T. H. and Klotz, S. D.: Bull. N. Y. Med. Coll., Flower & Fifth Ave. Hosps., 9:61, 1946. 3. Weinberg, J. et al.: Am. J. Dig. Dis., 15:332, 1948.

FORMULA: Each tablet contains 300 mg. pancreatin, U.S.P., 250 mg. pepsin N.F., and 130 mg. bile salts.

A. H. ROBINS CO., INC., RICHMOND 20, VA.

ENTOZYME®

Robins

A SINGULARLY effective, DOUBLE-layered tablet, with TRIPLE-enzyme digestive action.

Gastro-soluble enzymes are released from outer shell (A) *in stomach; entero-active enzymes from inner core* (B) *in duodenum and jejunum.*

March 10 a slip: "Call Mr. Nelson Smith for check-up."

Because the calendar never wears out, it will also remind us of actions to be taken several years from now. If Mrs. Melvin Jones tells me that today is her anniversary and that she has been married for twenty-two years, I will put into the calendar a note: "June 22, 1954—silver wedding anniversary, Mrs. Melvin Jones."

Frederick E. Ems, M.D.
Petaluma, Calif.

Watchmaker

I was much interested in your account of Dr. William Veling, spare-time watch repairman. Watch repairing also paid my expenses through college and medical school. When I began to specialize after graduation—I practice ophthalmology—I made the discovery that eye surgery is very coarse work compared to fine watch repairing.

Hans Schroeder, M.D.
San Francisco, Calif.

Sterile

"M.D., New Jersey" asks if he should take it upon himself to advise a prospective husband of his bride's sterility. Why should he? Here would be a clear-cut case of "the man who played God."

How many brides (or grooms) know for a certainty that they are capable of producing offspring? Besides, it was always my impression that most couples married out of a desire to be with one another, children being the by-product of

that desire. Marriage is supposedly for better or worse, and I believe that includes fecundity or sterility.

M.D., Maryland

Here's *my* advice to "M.D., New Jersey":

If you reveal to the groom that the bride is sterile, you're violating a professional confidence. It's the *bride's* duty to make this fact known to him.

I'm certain that her sterility would be grounds for annulment if the marriage took place. If she understands this, she may be ready to tell the groom.

Better to lose him now than to have the marriage go on the rocks. Happiness for a married couple cannot be built on such a deception as she would be practicing if she did not tell him.

M.D., Oregon

Competition

I am sorry to see you reflect disparagingly in your Sidelights department on the beliefs of as great a person as E. Stanley Jones in order to defend "competition." Being a good Christian, Mr. Jones naturally believes that motivation should be higher than a "driving urge to excel."

I don't see how a statement that Dr. William Mayo "wanted to be a better surgeon than any of his colleagues" is any credit to him. Many of us have seen the same spirit work to the detriment of fellow students, fellow staff members,

CHECK these two points when you prescribe a support:

1. That the support is so designed that it will NOT press downward on the abdomen.

   (A support that pulls downward against the abdomen INCREASES downward displacement of organs and places pressure on spine.)

2. That the support is so designed that it will NOT stretch out of shape.

   (A support that loses its shape, loses its effectiveness AND MAY BE HARMFUL RATHER THAN HELPFUL.)

Spencer Supports check on *all* points — *because:* Each Spencer is *individually designed, cut, and made* for each patient; each is guaranteed NOT to lose its shape (and to our knowledge is the only support so guaranteed); each is so designed that abdominal support is from below, upward and backward, paralleling the natural pull of abdominal muscles. Thus, muscle exercise is encouraged to help nature improve tonus.

In a Spencer the strain of supporting the abdomen is placed on pelvis, not on spine at or above lumbar region.

MAIL coupon at right—or PHONE a dealer in Spencer Supports (see "Spencer corsetiere," "Spencer Support Shop" or Classified Section) for information.

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fellow practitioners, and patients.

More to the credit of the medical profession than those who have reached the top through a self-centered will to excel are those who, with a spirit of cooperation and humility, have served in obscurity. They have been more than great doctors; they have been great men.

Gilbert W. Mellin, M.D.
New York City

I well remember hearing E. Stanley Jones speak one evening in San Antonio. He was fired with his subject (whatever it was) and at the end of his lecture he asked everyone who agreed with him to stand.

I just *sat*. My father sat too. Yet in that big auditorium I could see no one else sitting.

My views are the exact opposite of his. Yet I'm quite sure they're just as Christian.

Ess-Ella Breckenridge
North Little Rock, Ark.

"Is competition bad?" I'm afraid most doctors think so. Otherwise how can you explain the peculiarities of state medical licensure acts?

A fine dry climate, somehow, inhibits not only rheumatic fever and arthritis but also free competition. A sunny, healthful atmosphere provokes more regulatory legislation than does a cold, bitter winter, though the merits of the competitive spirit are theoretically the same, regardless of climate.

Everyone knows that laws regarding medical licensing have as

Here is the patient who can benefit most from

VERILOID*

IN HYPERTENSION

The patient with moderate hypertension, who constitutes the great bulk of hypertensives seen clinically, is the one that can benefit most from Veriloid. In his management, dosage is more simple, and the clinical response is as a rule excellent.

By controlling hypertension in its earlier stages, much can be accomplished. Many organic changes directly related to a sustained elevation of blood pressure can be prevented, expanding the years of physical and mental usefulness of the patient.

Veriloid—a distinctive, biologically standardized fraction of Veratrum viride—exerts its well-defined hypotensive action without sacrifice of postural reflexes so important for comfortable living. The average dose of from 2.0 to 5.0 mg. four times daily after meals and at bedtime usually produces a significant, sustained reduction in arterial tension. For optimal results, dosage should be carefully adjusted to the needs and tolerance of the individual patient.

HOW AVAILABLE IN THREE DOSAGE UNITS

Veriloid is now available in 3 tablet sizes —1 mg., 2 mg., and 3 mg. tablets. The larger tablets are especially useful after dosage needs have been established and are more economical for the patient. Literature available on request.

*Trade Mark of Riker Laboratories, Inc.

RIKER LABORATORIES, INC., 8480 Beverly Boulevard, Los Angeles 48, California

their sole aim the welfare of the public. Yet we find public welfare denying an established brain surgeon a license because he lacks three months of obstetrical internship and denying a dermatologist of international reputation a license because he inadequately recalls the intricacies of the temporomandibular joint. (Most examining board members, I wager, could not pass their own written examinations.)

Come now, be honest. Are medical licensing laws serving mainly to protect a defenseless public or to keep out unwelcome competition? What has happened to the universality of the National Board of Medical Examiners? What is the real philosophy behind basic science examinations?

The AMA could render a great service by working to standardize medical licensure.

Lester S. King, M.D.
Chicago

Mix-Up

You printed a map recently that confuses Oklahoma and Kansas as to their location. I would like to invite the maker of the map and your proofreader out to these states for a pheasant or quail hunt so they can get acquainted with the geography of our good old U.S.A.

R. W. Urie, M.D.
Parsons, Kansas

Thanks, but artist and proofreader had better settle for a geography primer.

a report of a revolutionary new development

in the management of congestive heart failure

Smith, Kline & French Laboratories presents:

RESODEC

Trademark

for sodium control

'Resodec' simplifies and ensures salt restriction by removing sodium—not from the dinner plate, but from the contents of the intestinal tract.

Why sodium restriction is so important in congestive heart failure

An outstanding characteristic of the patient with congestive heart failure is that he retains excessive amounts of sodium. And, to the extent that he retains excess sodium, he will accumulate excess fluid. Ten grams of salt retained will produce the accumulation of about a quart of water.

Now, the physician is entirely familiar with the complications caused by this excess fluid, which manifests itself as edema. Greater demands are made on an already failing heart. The renal blood flow and glomerular filtration rate decrease . . . causing an increased degree of sodium retention. This, in turn, leads to even more fluid accumulation and a renewal of the morbid cycle.

This is why it is vitally important (1) to restrict sodium, and thus (2) to prevent or arrest the retention of excess water.

The "low-salt" diet has always been difficult

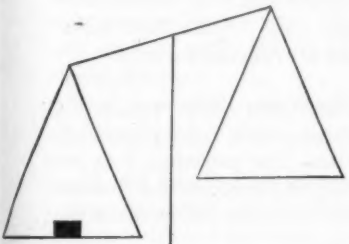
The "low-salt" diet has been advocated by leading specialists in congestive heart failure—primarily because, until recently, it has been the only direct method for the control of sodium.

The difficulties of this regimen, however, are many. The diet is almost intolerable, requires the preparation and expense of separate meals, and prevents the patient from dining out. **Finally, even after undergoing this ordeal, few patients actually attain the low sodium level that the regimen is intended to achieve.**

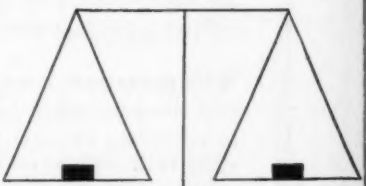
Resodec removes sodium . . .

At last—in Resodec—S.K.F. Laboratories has developed a new therapy which gives the physician a positive means of achieving sodium control—with virtually no danger of sodium depletion. This remarkable substance has the ability to remove excess sodium from the contents of the intestinal tract and to carry it out of the body in the feces. This removal of sodium permits the kidneys to excrete the excess fluid. Thus, the edema is controlled, the weight declines and the load on the heart is markedly reduced.

Resodec does not produce any significant physiological change whatsoever, except for the removal of excess sodium.



Sodium imbalance causes edema



'Resodec' restores sodium balance

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. . . without the danger of potassium depletion

Moreover—and this is highly important—Resodec does not interfere with the normal metabolism of potassium. Its prolonged use does not endanger electrolyte balance.

RESODEC OFFERS THE PATIENT AND PHYSICIAN 2 OUTSTANDING ADVANTAGES:

1. Resodec assures **adequate** sodium control.
2. Resodec frequently allows greater dietary freedom,
   . . . thus encouraging patient cooperation
   . . . and lessening the danger of protein deficiency.

How Resodec Is Synthesized

Resodec is one of a class of substances known as cation exchange resins. The class of resins to which Resodec belongs is entirely distinct from the "anion exchange resins". These latter, which attract negatively charged ions (anions), have found a completely different medical use, i.e., in the treatment of peptic ulcer. In the synthesis of Resodec, two important constituents are added to each 15 Gm. (single dose) of the basic resin: (1) Potassium ions (20 mEq.), and (2) Ammonium ions.

Why potassium is added to the resin. Potassium is the only element—other than sodium, of course—that is removed in significant amounts by the resin. The potassium ions are added to the resin to compensate for the potassium that Resodec removes. Thus, the possibility that Resodec will produce potassium depletion is eliminated.

Why ammonium is added to the resin. The ammonium that is added to the resin serves two purposes:

1. The ammonium form of the resin provides maximum palatability.

2. The ammonium ions—when they are released—combine with chloride ions to form ammonium chloride, a mild diuretic.

What Resodec is

Resodec is a virtually inert and completely non-absorbable substance. It is a refined, white, easily pouring powder—odorless, tasteless, and of a pleasant consistency.

With Resodec there is no evidence of toxicity

Acute and chronic toxicity studies on Resodec have been negative.

Studies of stools of Resodec-fed animals showed that Resodec does not interfere with the absorption of essential nutrients and minerals. Hemoglobin, red blood count, hematocrit and white cell count were entirely normal.

How Resodec Works

The basic action of Resodec can be most simply explained as two separate chemical exchanges:

1. In the acid medium of the stomach, Resodec releases the potassium and ammonium ions that have been bound to it.

The potassium ions compensate for the potassium that the resin will remove when it reaches the intestinal tract. The ammonium ions combine with chloride ions to form ammonium chloride, a mild diuretic.

In exchange for the potassium and ammonium ions which have been released, the resin takes on some hydrogen ions.

2. In the alkaline medium of the lower small intestine, a second exchange occurs. The resin attracts and binds to itself sodium ions (and also some potassium ions). In exchange for these sodium ions, the resin releases the hydrogen ions that it picked up in the stomach.

The sodium that is bound by the resin is "carried" out of the body in the feces.

In short, Resodec removes excess sodium without producing any other significant physiological change. Therefore, the net result is a low sodium effect.

Continued on next page

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The chronic toxicity studies are of special interest because Resodec is, in most cases, a long term medication. These chronic toxicity studies—where Resodec was used in animals over a long period of time—showed no pathology suggestive of toxicity.

Indications

Resodec is indicated wherever a "salt-free" or low salt diet is required in the management of congestive heart failure and cirrhosis.

Contraindications

The use of Resodec should be limited to the indications listed above. Its use is contraindicated in the presence of definite renal insufficiency, glomerulonephritis, oliguria and anuria.

Therapeutic effect

In the majority of cases, if the patient uses Resodec as directed, omits table salt, and eliminates excessively salty foods such as bacon—

(1) his edema will be controlled,
(2) his weight will decline,
(3) and the load on his heart will be markedly reduced.

Quantitatively, Resodec produces the approximate effect of halving the patient's salt intake. The following figures provide a general guide:

Salt intake (per day)	Resodec initially will remove
7-12 Gm. (mild case—normal diet)	3-4 Gm.
3-6 Gm. (moderate case—moderate restriction)	1½-3 Gm. (50%)
1-2 Gm. (severe case—drastic restriction)	1 Gm., or less

Dosage and Administration

The daily dosage of Resodec is 1 packet (15 Gm.) three times daily, at mealtime. The therapeutic effect should be regulated by varying the dietary intake of sodium—not the dosage of

Resodec. The proper degree of dietary restriction may be determined by observing the response of the patient, just as with the "salt-free" diet. (See Diet section, below.)

Resodec may be taken with fruit juice, milk or water, or in any other way that is convenient for the patient. Because individual tastes vary so widely, it is desirable to encourage the patient to experiment with different ways of taking Resodec.

Diuretics

Obviously, in the markedly edematous patient, even with Resodec therapy, mercurials or other diuretics are sometimes required to hasten the return to normal fluid balance.

As the edema disappears, however, Resodec becomes the major therapy. It helps maintain the normal fluid balance by removing sodium—just as the "low-salt" diet is intended to do. In all but the most severe cases, use of Resodec should eventually diminish the need for diuretics.

Diet

In most cases, Resodec does not eliminate the necessity for some dietary restriction of salt.

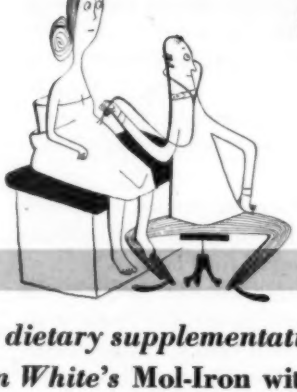
The majority of patients using Resodec, however, will be satisfactorily maintained on normal household cooking if they merely eliminate salt at the table and omit excessively salty foods such as bacon.

In more advanced cases, additional dietary restriction of sodium will probably be required, i.e., (1) no salt added in cooking and (2) careful selection of low sodium foods.

The precise degree of dietary restriction required with Resodec may be determined by observing the response of each patient—just as with the "salt-free" diet. But—whatever the degree of dietary restriction—it will be far more therapeutically effective in conjunction with Resodec therapy.

How to write for Resodec

When prescribing Resodec, be sure to write for 1 carton. Each carton contains one week's supply—21 single dose (15 Gm.) packets. Complete directions for administration appear on each packet.



Specifically for the Pregnant Patient

***For dietary supplementation, there is nothing better than White's* Mol-Iron with Calcium and Vitamin D**

Now for convenience in prescribing to pregnant and lactating patients, Mol-Iron—the most effective iron therapy known[1, 2, 3]—has been supplemented with generous amounts of calcium and phosphorus in an optimum ratio plus adequate vitamin D.

Each easily swallowed, soft gelatin capsule contains:

Mol-Iron	198 mg.
Dicalcium Phosphate (anhydrous)	869 mg.
Vitamin D_3	200 units

Prophylactic Dose: One capsule three times daily after meals.

Therapeutic Dose: Two capsules three times daily after meals (providing 240 mg. Fe daily).

Supplied: Soft gelatin capsules in bottles of 100.

Also: Mol-Iron Tablets in bottles of 100 and 1000; Mol-Iron Liquid in bottles of 12 fluid ounces; and Mol-Iron with Liver and Vitamins, capsules in bottles of 100.

White's Mol-iron®

WITH

CALCIUM AND VITAMIN D

WHITE LABORATORIES, Inc., Pharmaceutical Manufacturers, Newark 7, N.J.

1. Dieckmann, W. J., and Priddle, H. D.: Am. J. Obstet. & Gynec. *57*:541, 1949
2. Chesley, R. F., and Annitto, J. E.: Bull. Margaret Hague Mat. Hosp. *1*:68, 1948
3. Dieckmann, W. J., et al.: Am. J. Gynec. *59*:442, 1950

Sidelights

Leadership Problem

The high cost of serving as a medical society officer is by now pretty well known. Last year, for example, this magazine published the results of a survey among nearly a hundred of the country's most active medical leaders. Findings:

¶ They devote 15.5 hours a week, on the average, to medical society work. That amounts to 775 hours a year.

¶ They contribute an average of $121 a week to this work, in out-of-pocket expenses and decreased earnings from practice. That adds up to more than $6,000 annually.

With these figures in front of you, it's easy to understand why well-to-do specialists are often the only ones willing to serve.

Yet this is a distinct weakness in our medical society set-up. It perpetuates the notion that organized medicine is run "by and for a small clique." It gives rise to criticisms like the following, voiced a few months ago in these pages:

"The financially successful specialist seems to be too much admired in AMA circles. Nearly all policy-making posts are filled by such men. General practitioners, young doctors, and small-town medical men have practically no voice at all. In this respect, at least, our top command does not represent the rank and file."

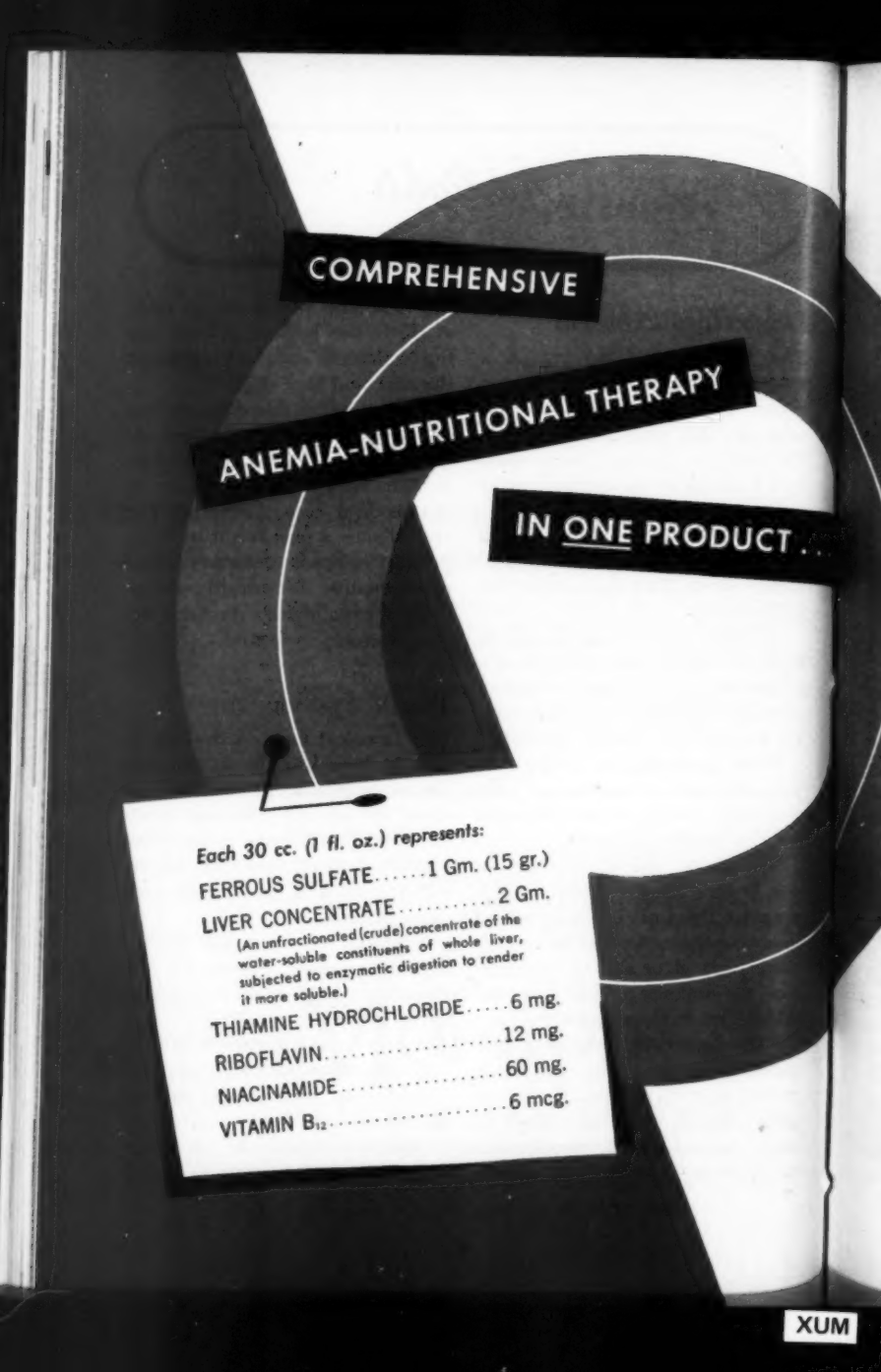
A way out of this dilemma has been suggested by Dr. Fred A. Humphrey and other Colorado physicians: Why not pay salaries to top medical society officers? The cost of such a plan might be high; but the dividends—in terms of more representative leadership—might well be even higher. We think the idea warrants early study.

Recall System

Most medical men, as we see it, lean backward too far in the matter of reminding patients to visit them for needed follow-up work. In several cases we've heard about recently, patients view this conservatism as lack of interest or even as negligence.

Suppose you have just finished treating a patient. Suppose his condition warrants another check-up in six months or a year. It's a simple matter, as the patient is leaving, to mention this and to ask him: "Would you like to have us send you a reminder?"

Almost invariably, in our experience, the patient *wants* to be fol-


COMPREHENSIVE
ANEMIA-NUTRITIONAL THERAPY
IN ONE PRODUCT . .
Each 30 cc. (1 fl. oz.) represents:
FERROUS SULFATE . . . . . 1 Gm. (15 gr.)
LIVER CONCENTRATE . . . . . 2 Gm.
(An unfractionated (crude) concentrate of the water-soluble constituents of whole liver, subjected to enzymatic digestion to render it more soluble.)
THIAMINE HYDROCHLORIDE . . . . . 6 mg.
RIBOFLAVIN . . . . . 12 mg.
NIACINAMIDE . . . . . 60 mg.
VITAMIN B_{12} . . . . . 6 mcg.

Supplies these important hematopoietic-nutritional factors in a well-balanced formula:

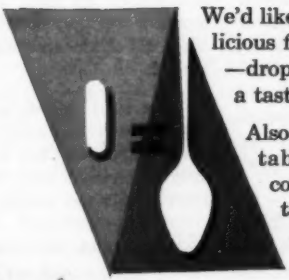
IRON IN FERROUS FORM—chemically stabilized, well utilized.

LIVER CONCENTRATE—in unfractionated (crude) form, preserving all the water-soluble erythropoietic and nutritional principles of whole liver . . . *enzymatically digested*, providing maximum solubility to assure assimilation.

B VITAMINS—including vitamin B_{12}.

Hepatinic®

McNEIL



We'd like to have you try the delicious flavor of Hepatinic elixir—drop us a card and we'll send a tasting sample.

Also available in convenient tablet form:—each sugar coated orange tablet containing the equivalent of 5 cc. (one teaspoonful) of the Elixir.

McNeil LABORATORIES, INC.

PHILADELPHIA 32, PENNSYLVANIA

FOR YOUR FILES . . . THIS **Birth Announcement**

ARMOUR

Now — 6 choice meats for the bassinet crowd: Gerber's Strained Beef, Veal, Liver — and new Lamb, Beef Hearts and Pork. All true-flavor and true-color. All prepared from tender, extra-lean Armour cuts. The same facts apply to Gerber's Junior Beef, Veal and Liver.

Gerber's easy-to-digest meats mean less worry for you, less work for mothers. Yet they cost far less than if Mom did all the scraping and cooking herself.

Do you start infants on cereal and meat simultaneously? Nowadays many doctors do. Only Gerber's, whose only business is baby-feeding, offers both cereals and meats.

FOR COMPLETE MEAT ANALYSES please write on your letterhead to Department 224-I, Fremont, Michigan.

Babies are our business . . . our only business!

Gerber's
BABY FOODS

lowed up. And when you later mail him the reminder, you can quite properly say that it's being sent at his own request.

In any event, don't be *too* cautious about issuing follow-ups. They're generally regarded not as "business-builders" (which some doctors apparently fear) but as a real service to patients. And service, after all, is what most people are looking for.

Without License

We drove up to the Westchester County (N.Y.) Penitentiary the other day for a talk with William R. MacLeod, who's serving a twelve-month term there for practicing medicine illegally. Perhaps you remember his story: how a onetime Army medic, who'd never gone beyond high school, worked for five years as an interne and resident in a score of eastern hospitals. We wanted to get some idea of how he'd managed it.

We didn't find out, but we had an interesting talk just the same. MacLeod turned out to be short and a bit pudgy, with a clipped mustache and receding black hair. He seemed uncomfortable on his straight-back chair in the warden's office. Warden Paul Brown, meanwhile, learned back in his swivel chair, interjecting a comment from time to time.

We asked MacLeod whether he'd told anyone the real story yet. "Not me," he retorted, fumbling with his pipe. "I haven't said a word since I was arrested last September. Both the police and the warden here managed to hold off reporters. Whatever information they got came from hospital authorities—and that's not the whole story, by a long shot. For example, they said I delivered 475 babies. Actually, I delivered more than a thousand."

Here the warden spoke up. "MacLeod," he said, "has been offered up to $1,000 for his story. He's turned down all offers so far because he doesn't want to hurt himself any more than he's been hurt already. We've had men here from topflight magazines. A reporter from the Associated Press camped on our doorstep for a week. You're the first one to see him. But whether he'll talk or not is entirely up to him."

MacLeod, it turned out, did not choose to talk. Not at our prices, anyway. His only interest in publishing any story, he kept repeating, was the money it would bring. "It's time I started thinking of myself," he said. "I'm almost 40 and I've got to make my life over. I can't go on giving away my services like I've been doing."

We asked him to explain. "Here's the reward I got for my hospital work," he said slowly. "Salary: $125 to $150 a month. Working hours: twenty-four to forty-eight at a stretch. Plus the empty satisfaction of doing the jobs licensed doctors—high-ranking ones, at that—weren't competent to do. I had to live at

the hospitals, away from my wife, because I was on duty so much. Sure, every doctor goes through interneship. But how many of them would do it if they knew they'd never reap the rewards of private practice?"

We suggested that some doctor reading of his plight might help him. "Not a chance," he laughed. "Even if an M.D. wanted to help, he couldn't. Organized medicine is too jealous of its vested rights. They'd never let me go before an examining board. How do I know? Because the warden's already tried to have an exception made in my case. It was no use."

"Suppose you *could* take a board exam. Do you think you'd pass it?"

"After reading every medical text I could get hold of for sixteen years? Of course I'd pass it. Look, I was a senior resident once. One of my jobs was to teach other house officers how to pass *their* boards. They got by all right."

He drew on his pipe for a moment. Then he added: "I'd gladly pay for any publicity that would give me a crack at an examining board. But that's just about hopeless. My only course is to get out of medicine entirely."

"Couldn't you qualify for some secondary medical school?" we persisted.

"The warden tried that too. Even the licensing official who prosecuted me last fall looked into it. But you need undergraduate credits—which I don't have."

As far as MacLeod was concerned, the interview was over. We shot a last question at him: "Would you have kept on interning if you hadn't been uncovered?"

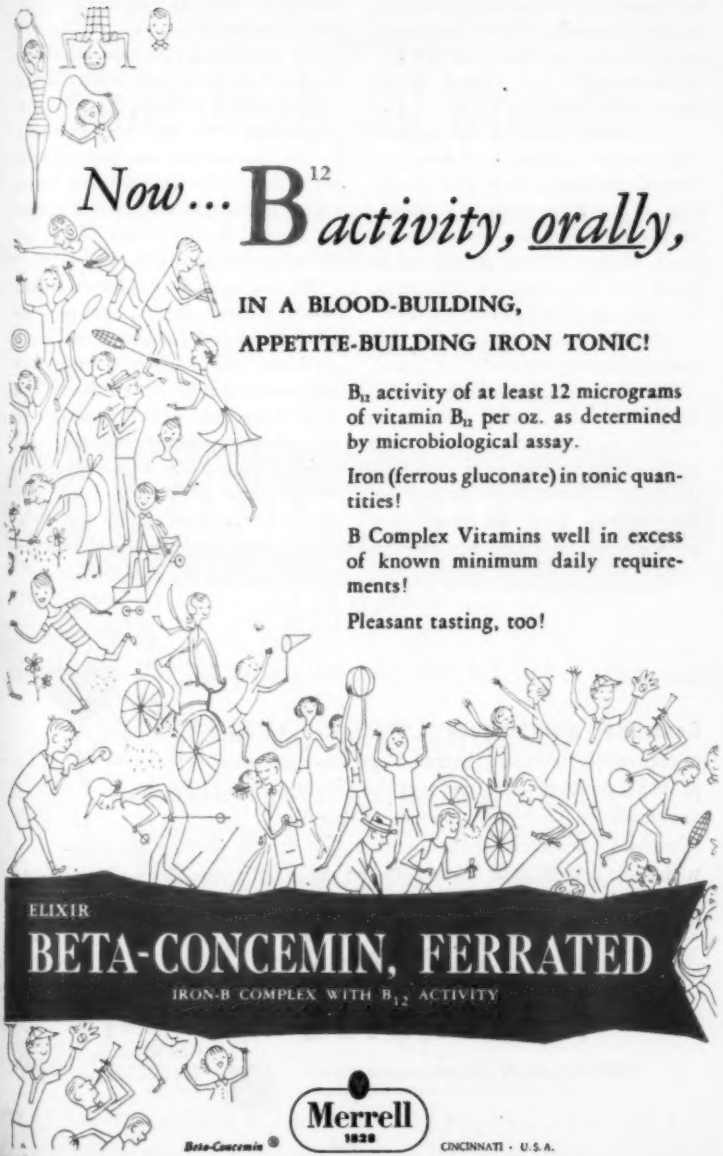
"Probably," he conceded. Then, after a moment's reflection: "I'd probably have spent the rest of my life doing the same thing."

He turned to the warden. "Is that all, Mr. Brown?" When the warden nodded, MacLeod squeezed past us on his way to the door. As he went by, we wished him good luck. "Sorry you had the trip up here for nothing," he said. Then the guard was taking him back to his cell.

"It's a waste of valuable talent," said the warden, motioning after MacLeod. "Especially when they talk of a doctor shortage. All the medical men I've spoken to agree that he's capable. He had to be, to get by for five years as he did. Don't forget, he changed jobs every few months to play it safe. And every place he went for a new job, he convinced the medical authorities he was genuine. He got all the references he needed, too.

"You probably know why he was picked up," the warden continued. "Not for any lack of medical knowledge. He fell behind on payments on his car—not surprising in view of the salary he was making. The New York police happened to check his name with the State Department of Education—and there you are."

We remembered hearing that MacLeod, at one time or another,



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had served as a resident in surgery, ob.-gyn., neuropsychiatry, and even geriatrics. So we asked the warden if he actually was versed in all those specialties.

"I honestly think so," he replied. "He has an uncanny knowledge of general medicine. He's also an expert on psychoanalysis and hypnosis. He used hypnosis in maternity cases. Matter of fact, he offered to teach me hypnosis—it's something I've been dabbling in for years."

"Did he really manage all this without hurting anyone?" we asked.

"He claims he never harmed anyone," said Mr. Brown. "I see no reason to doubt it. The police couldn't dig up any evidence to the contrary. When a case became too complicated for him, he knew enough to call in somebody who could handle it."

We wondered out loud whether MacLeod got any fan mail. "Bags of it," replied the warden. "Some people just wish him well. Others try to worm free medical advice out of him. The topper came from a man in Florida who runs a home for alcoholics. He wants MacLeod to be his house doctor."

We got up to leave. As we shook hands, Warden Brown summed up what MacLeod himself must have realized: "He made a wrong start and never managed to make it up. If he'd directed half the energy to becoming a real doctor that he put into fooling the authorities, he would have become a legitimate medical man. And a good one, too."

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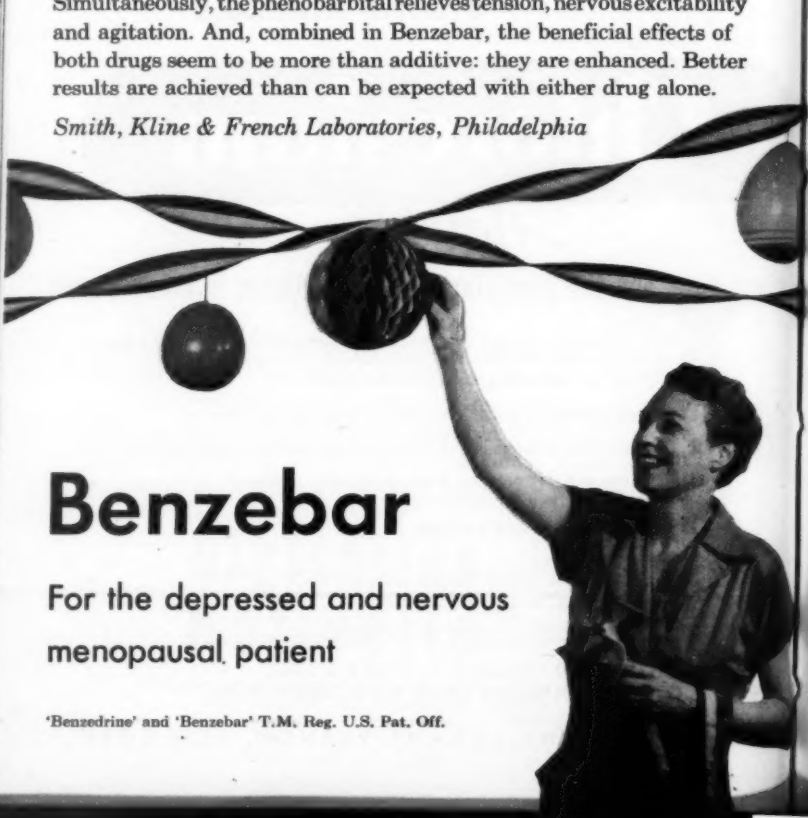

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Editorial

Goodbye to Charity

• About a year ago, you may remember, Oscar Ewing was awarded a medal for what was described as his campaign to "destroy the curse of charity" in medicine.

While this phrase may grate strangely on the ears of Bible-readers, it accurately reflects a certain discontent—at least on the part of the labor people making the award—with the time-honored system of charity medicine.

But today the system is not what it used to be. Take a look at the trend:

Back in the mid-1930's, according to surveys conducted by this magazine, the average private physician donated fully 25 per cent of his time to charity work. By the mid-1940's, he was donating only 10 per cent of his time. By the mid-1950's, he may be donating little or no time.

Is this a wholesome trend? We think so. For one thing, it reflects the burgeoning economic health of American families since depression days. More important to medical men, it also reflects the steady spread of voluntary health insurance. People who cannot pay lump-sum medical fees often *can* pay small monthly premiums for the same purpose. "This," as Dr. Paul Hawley points out, "has decreased the amount of charity work required and has increased the self-respect of many families with marginal incomes."

What about those who *still* can't afford to pay the few dollars a month in health insurance premiums? Even for such people, charity medicine is on the way out. It's being replaced by a variety of tax-supported welfare plans that seek to avoid the old system's stigma.

Not that city and state plans for indigent care are working smoothly yet. But they do offer patients a promise of medical care in the best traditions of private practice. They do offer physicians payment for work formerly done free. In cities like Baltimore and Newark, in states like Washington and New York, local tax-supported plans have shown that they *can* do the job.

Where such plans haven't yet clicked, the missing ingredient is often medical support. Which puts it squarely up to our profession:

If we really get behind these local welfare plans, we can wipe out the alleged "curse" of charity medicine—without any help from Oscar.—H. SHERIDAN BAKETEL, M.D.

How to Survive a Cross-Examination

Courtroom visits will be less strain if you answer each question on its own merits

● The attorney who has called you to the witness stand is winding up his direct examination:

"Now, Doctor, on the basis of all you've told us, can you say with reasonable certainty that the accident was a competent producing cause of the patient's coccydynia?"

"Yes," you answer, and he nods approval.

"And that's a painful condition, is it?"

"Yes." Again the approving nod.

"And disabling?"

"Yes. The pain at the tip of the spine is increased by sitting, walking, and driving—all of which she has to do in her work. At times it is excruciating. She has been forced to discontinue that work."

This time a nod plus a happy smile from the attorney. Then he puts the final question:

"And, as you've told us, her condition is, in your opinion, permanent?"

"That's right."

"Thank you, Doctor." He bows his gratitude to you and starts back to the counsel table. En route, he wags his head sadly to indicate to the jury the awful shape his client is in. Then, with a casual wave to the opposing lawyer, he says, "You

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**Bernard R. Lauren, the author of this article, is a New York trial attorney and a member of the Medical Jurisprudence Committee of the New York City Bar Association.*

may cross-examine the doctor."

He's happy as he sits down. Your testimony for him has been "beautiful." It contains all the medical ingredients that add up to large verdicts:

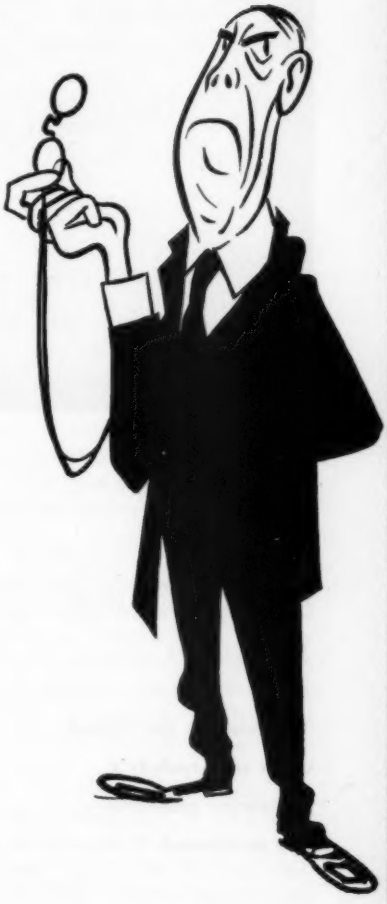
1. The client has a malady.
2. It was caused by the accident.
3. It is painful.
4. It is disabling.
5. It is permanent.

Will your testimony hold up? How can it be undermined in the eyes of the jury? That's precisely the question the opposing lawyer is pondering as he rises to cross-examine you. He knows that he has, in general, two possible avenues of approach: (1) He can attack you personally, or (2) he can attack your testimony.

In the case of the painful coccyx, he rules out the first line—perhaps on the ground that you're too well known in the small community where the trial is being held. You may even have treated some of the jurors or members of their families. They'd resent any personal attack on you. So he decides to go after your testimony.

His objective? An attack on your opinion as to some or all of the five medical ingredients.

His weapons? Chiefly two: first, logic (it isn't always *sound* logic, but it may seem impressive to a jury unversed in medicine); and, second, opinion contrary to yours found in authoritative medical works. [*Continued on* 203]



They Settle Doctor-Patient Disputes

A report on the actual cases one society's grievance machinery has processed

● One day last fall, a young woman stormed into the third-floor offices of the Westchester County Medical Society in White Plains, N.Y.

"I read about your new grievance committee in yesterday's paper," she told a receptionist, "and I want to file a complaint against a doctor."

The receptionist turned the woman over to the society's executive secretary, Boyden Roseberry. As he listened, the woman told her story:

Four years earlier, she claimed, a physician had cut open a cyst on her neck. He must have made a terrible mistake because, ever since, one side of her face had been par-

alyzed. She was ashamed to meet people. She had been forced to quit her job in a millinery shop. Couldn't the society help her?

Two weeks later, her case came up before the society's seven-man grievance committee. They called the doctor in question, found that the "cyst" had really been a malignant tumor of the parotid gland. In operating on it, the doctor had severed a facial nerve, which had caused the paralysis.

Committee members checked with specialists in neurosurgery. Their opinion: The physician was not at fault. In an operation of this type, there was always a chance that the nerve might be cut. The woman had just been unlucky.

At this point, the society's full-time social service consultant, Katherine Russell, took over. In simple and sympathetic terms, she told the woman about the committee's findings. She urged her to face up to her misfortune, go back to work. After several such talks, the woman was convinced. She stopped brooding and got back her job.

Patients in Westchester County have been free to drop such complaints in the medical society's lap since last September. It was then that the society announced its new P.R. program*—an announcement that got front-page play in the county's eight dailies.

Modeled after the time-tested formula of the Alameda County (Calif.) Medical Society, the program had been approved by physician-members with but one dissenting vote. Privately, however, some M.D.'s had expressed doubts. Said one: "It may have worked in California but I'm not so sure it will go here. After all, Californians will try anything—as long as it's new."

P.R. Results

Today, many such doubts have vanished. In its first five months of operation, the grievance machinery has already ground out some impressive results. Says Executive Secretary Roseberry: "What amazed us most was the regeneration of our medical society in the eyes of the community. Letters asking our help with all types of medical care problems have poured in as never before."

Has the grievance machinery really helped ease doctor-patient friction? Best answer to that is the actual case records in the society's files. These records show that misunderstanding—usually over fees or results of treatment—are the cause of most patient gripes. Two cases in point:

A few days after the P.R. program got under way, an irate woman complained that a doctor had "ruined" her 2-year-old boy. One of the child's testicles had receded after the doctor had performed a herniorrhaphy. The woman had refused to pay the doctor or take the

*Including a grievance committee, a collection bureau, a malpractice prevention committee, and an emergency medical service.

Can't Do It Alone

boy back to him for further treatment.

The doctor wasn't too concerned over the bill. What bothered him most was that the child was not getting the necessary follow-up care.

After an investigation, the case was turned over to the social service consultant. Katherine Russell visited the woman, explained that the results of the operation were not unusual for a child that young, and emphasized the importance of returning the boy to the doctor for further attention. After three such social service visits, the mother agreed. Both the patient and the bill were promptly taken care of.

Some weeks later, a distinguished-looking man in his forties stomped furiously into the society's offices. "That lying chiseler, Dr. ——, won't get another penny out of me," he sputtered. "Let him sue if he likes." In words charged with anger, he unloaded his complaint:

His mother had been taken to the hospital with a heart attack. The total bill had come to $348. Worried about how he was going to raise that much cash, the man had buttonholed the doctor in the hospital corridor. The doctor's offhand response: "Oh, do the best you can."

Taking this remark literally, the man had managed to scrape up $200 in three days, sent it in thinking the debt was discharged. He exploded when he received a bill of $148 for the balance.

A little reasoning brought the man's temperature down. "Most doctors are somewhat reluctant about discussing fees," explained Mrs. Russell. "But it hardly seems fair to set your own price without reference to the value of the service." Before the man left, he had arranged to pay off the remaining $148 in reasonable installments.

Nor are all misunderstandings on the part of patients. For example: A woman got a chicken bone lodged in her throat. She was rushed to a hospital, where an ENT man removed it. Since she was covered by Blue Shield, and since total family earnings ($2,200 a year) were within the income limit for full service, she expected no bill from the physician. The prepay plan was supposed to cover it.

But the specialist hadn't bothered to ask about her income. Noting that she lived in a fairly good section of town, he had mailed her a supplementary bill of $65. When the facts were presented to him, he quickly canceled the additional charge.

In another instance, a physician sent a bill of $180 to a woman with an income of $25 a week. She had nine children to support. When the medical society suggested he adjust the bill in the light of the circumstances, he promptly canceled it in full.

Not all complaints, of course, are *bona fide*. About 2 per cent come from assorted crackpots, deadbeats, and psychopaths.

[*Continued on* 181]

Having Consultant Trouble?

The etiquette book for consultations requires plenty of two-way stretch

● The consultant—like television—is here to stay.

Of course, there *are* family doctors who call in consultants only when the patient is at death's door. And G.P.'s whose vanity is wounded when the family even hints at consultation. But if the relatives really *want* a specialized opinion, they'll get it one way or another. The experienced practitioner goes *with* this tide, not *against* it.

From the G.P.'s viewpoint, the trouble with a consultant is that (a) he may imply the family doctor has bungled; or (b) he may take over the reins so fully that the G.P. never sees the family again; or (c) he may run up so high a bill that there's nothing left to pay the family doctor with when his turn comes. These are the general

practitioner's three chief gripes about specialist services.

A well-established specialist may choose to laugh off these complaints. But he's better advised not to give a family doctor grounds for such grievances.

No consultant *wants* to make the G.P. look like a bungler. But he can do so unintentionally; for he's in an awkward position: If he *doesn't* alter the treatment, the relatives wonder why they have to pay a large fee for his services. If he *does* alter treatment, it looks as if the G.P. must have been wrong.

Most successful consultants work the dilemma out along these lines: If there is medical indication for a change, they talk it over first with the family doctor. They arrange to have the change take effect in a few days. To the family, the consultant then says: "Dr. Smith's treatment is exactly what I would have recommended myself. But if he (the patient) does not improve by Sunday, we'll use another approach."

This suggests that the family doctor was doing all right but that the consultant's visit was justified in terms of possible future changes. The altered program, if found necessary, will sound like a cooperative venture between the two doctors.

"Patient-stealing" charges are nearly always the result of one doctor misunderstanding the other. The family physician is the one calling the signals; it is up to him to call them right. He must indicate clearly whether the referral is for consultation only or for treatment. If he doesn't specify, perhaps he can't honestly blame the specialist for assuming control.

Suppose a G.P. who has been treating a hypertensive for years finally sends him to a cardiologist. He phones and says: "I'm referring a Mr. Remsen to your office. When can you see him?" The cardiologist naturally assumes that he is supposed to treat the man.

If that is *not* the G.P.'s idea, he can say in his phone call: "Please check on him and send me a report. I'd also appreciate any tips on treatment you could give me. I've had him on X and on Y and on Z. I wonder if there is any other medication you'd advise me to try."

This makes it crystal clear that Mr. Remsen is being lent, not given to the specialist.

What Will the Fee Be?

The fee question has, of course, soured more than one G.P.-specialist relationship. Suppose the family doctor is referring a possible kidney case to a urologist for cystoscopy and opinion. The patient is concerned about the cost of this service. Will it be something like $10, or nearer $100? The family doctor can handle this poser in one of three ways:

1. *He can guess.* Which is a good way to break up a beautiful friendship all around. The specialist resents someone trying to set his

fees. The patient resents being charged more than he's been led to expect.

2. *He can say he simply doesn't know*—that he can't even begin to estimate the fee. This makes the G.P. look like a babe in the woods. It may even suggest that there's something underhanded going on.

3. *He can call the specialist and ask.* This is the method used by experienced family doctors. It gets the facts, gets them correctly, gets them promptly. It allows the G.P. to suggest to the specialist why—if it is true—a smaller fee may be in order in this case.

Where the G.P. Errs

From the specialist's viewpoint, the trouble with the G.P. is that

(a) He doesn't send enough information;

(b) He doesn't indicate whether he wants action or just advice;

(c) He doesn't make it clear how much each doctor is to tell the patient; and

(d) He may have used the wrong criteria in selecting the specialist. On the latter point, there is little to be said except the obvious: that loyalty to the patient is a more durable virtue than loyalty to a classmate, fee-splitter, or fraternity brother.

Clogging up of the information channel is usually due to the G.P.'s being a busy man who hates to write letters. So he gives a sketchy verbal report to the specialist—and is then annoyed when the latter duplicates an expensive liver-function test or X-ray series.

The solution? Send the specialist a written report that includes test findings and the originals of the X-ray films. It takes time, but it smooths doctor-doctor relationships and spares the patient's time and pocketbook.

One matter that may require an offstage agreement between the doctors is the decision as to who talks to the patient after the consultation is over. It doesn't really matter who does it as long as the M.D.'s don't get their wires crossed.

When the patient comes to the specialist's office, for example, the G.P. is not likely to be present. At the end of the visit, the patient may ask: "What's the verdict?" Does the specialist tell him? Or does he say: "I'll send a full report to Dr. Brown"?

This problem is best cleared up during the referring phone call. The specialist may ask: "Shall I tell him diagnosis and outline the treatment, or would you rather do that after you get my report?" Or the G.P. may clarify it thus: "If you don't mind, I'd prefer that you send the patient back to me for any interpretation. Of course I'll be guided by your report."

In a home or hospital consultation, protocol requires that the G.P., at some point, offer to leave the specialist alone with the patient. The consultant may ask the family doctor to remain; but it saves embarrassment if the G.P. at

least offers to withdraw for a while.

In a subsequent private caucus, the two doctors naturally discuss diagnosis and treatment. But too often they forget to discuss tactics too. They may come down the stairs together and run into a barrage of questions. Then comes a sort of Alphonse-and-Gaston act: "*You* explain it, Doctor." "No, *you* tell them." The remedy is simple. The report to the family is arranged beforehand, the choice always being left with the family doctor.

Perhaps the most delicate problem in this field is whether the specialist should continue to see the dying patient to the end. The chore is unpleasant. Naturally, each doctor prefers that the other be in at the death. Sometimes the specialist, after attending the patient for months, bows out, saying: "I have done all I can. I'm asking your family doctor to carry on from here."

Though said ever so tactfully, this is clearly recognized as a death warrant. The relatives generally feel that the big-fee specialist has deserted them in their hour of desperation. So the specialist who is sensitive to such nuances *does* stay to the end—simply because his presence implies hope and superior care.

Most men, unfortunately, are too busy. So they turn this unhappy duty over to the family doctor. For he is the one man who can never evade it.—HENRY A. DAVIDSON, M.D.

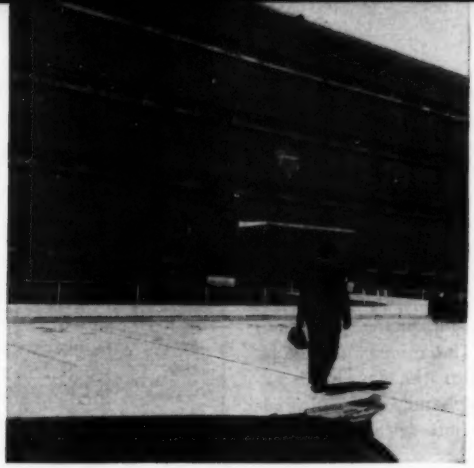
What! A Doctor Without a Hobby?

● Among today's social mores, having a hobby rates about on a par with sound dental habits. Some good, after-hours obsession, we're told, is essential to the well-rounded life.

Physicians are among those constantly being urged to take up a hobby. A popular one now is painting—endorsed by magazines, psychiatrists, Churchill, and Grumbacher. This is an excellent choice of first hobby (a phrase that justifiably assumes you will go on to other hobbies) since, by definition, anyone with a brush in hand is "talented." There are merely degrees of talent.

A special philosophy exists for the amateur artist. If you get more paint on the canvas than on your oriental rug, you are expressing yourself. Vice versa, and your wife expresses *her*self.

In painting, you have the advantage of a captive audience. Even the strongest-willed member of your family will [*Continued on* 173]



Why I Prefer Industrial Practice

Less hurry, surer income, fewer night calls are big assets, says this physician

● My wife and youngsters now see me around the house once in a while. I even squeeze in a bit of golf and fishing, some non-medical reading, and an occasional evening with friends. Those are among the reasons why I eased over into industrial medicine after the war.

I soon discovered this field has other advantages too. So I'm now doing industrial work almost exclusively and have no wish to climb back on the private practice treadmill.

For one thing, industrial work is devoid of collection worries. I treat the patient, sign the slip, and in comes the insurance company's check. No questions, no haggling, no dunning. What's more, the company never kicks about the

cost of therapeutic or diagnostic measures. The more X-rays, for example, the better; they're looked on as protection against possible law suits later.

Emergency Work

Night calls? I average one or two a year. Sunday work is equally rare. Saturday I'm on emergency call, but have no clinic hours. And when I want to knock off for a couple of weeks, it's easy. I get one of my industrial colleagues to cover for me, then leave town in the knowledge that my absence won't cost me patients.

My bailiwick is an eastern industrial city of some 110,000 population. Soon after I opened my office there in 1938, I joined the Elks. In a couple of years my club contacts brought me my first industrial work—a contract with a small department store that has 175 employes. I didn't seek it out. It was simply offered to me, as were three other connections I've made since then.

You don't have to sport an Elk's tooth, of course, to line up industrial contacts. It just happens that in my town the Elks Club attracts most of the businessmen. In yours, it may be Rotary, Kiwanis, the country club, or some church or civic organization. If you're really out to make connections, you can probably do it much faster than I did.

My next two jobs—with a sewing machine company (9,000 employes) and the local packaging branch of a big oil company (thirty-seven employes)—weren't permanently nailed down until 1942. The next voice I heard was that of the Army Medical Corps.

When I got out of uniform in 1945, all three jobs were waiting for me. Soon a fourth one—with a railroad—brought another 2,000 patients under my charge. Thus my industrial work became virtually full-time.

Incidentally, the railroad connection came about through my cover work for other industrial M.D.'s. Having decided I wanted to make industrial medicine my specialty, I kept my ears open around the hospital to learn which of my older colleagues were most active in the field. Then I called on a half-dozen or so, offering to pinch-hit in emergencies or during their vacations. I got some free-lance experience that way and, when one of them decided to retire, the railroad job dropped into my lap.

Doctor's Day

Theoretically, I work a twelve-hour day. Actually, I set my own pace. I get away from the house about 8 A.M. and make my first stop at the oil company. Here the men handle heavy drums, so my work runs mostly to bruised or broken feet and toes. Next I move on to the sewing machine company or to the railroad offices. Lacerations, fractures, and back sprains are the usual problems here; more

serious accidents involving amputations are also an occasional part of railroad work. I have no clinic hours at the department store; I just stop around there when someone has cut a finger or tumbled downstairs.

Both the railroad and the sewing

SPEEDSTER

• Dr. J. P. Young says he's "as nearly an old-fashioned country doctor as you can be in California." But the folks in Lemoore (pop. 2,400) consider him a pretty streamlined G.P. And with good reason; for he habitually spins around town on house calls in an open-cockpit Duesenberg racer. Fact is, this county medical society president is also a spare-time racing-car builder and past president of Lemoore's Auto Racing Club. His latest pride is a three-quarter-size midget, the fourth such car he has designed and built in his own backyard workshop. Its unique engine was touted recently in an auto magazine, drew interested queries from seventy top designers.

A machine-shop stint at 18 gave Dr. Young the know-how to build gasoline-powered model airplanes and boats. In 1938, a chance to drive a few fast laps in a midget racer infected him with a new bug. Today, the 44-year-old physician works four or five hours a night on his cars, drives them in local races on weekends. Only mishaps to date: "two minor spills on my head." Cost of his hobby? About $18,000 so far. The return? "It's a tingling thrill to win a race in a car you've built yourself."

Now taking shape in Dr. Young's workshop is a bigger and better racer. His goal: to have a Young-built car win the 1952 Memorial Day classic in Indianapolis. END

machine company have well-equipped clinics, with four or five nurses each. I may see up to 200 people in a single session—mostly minor stuff that the nurses handle and I merely check on. I'm supposed to spend nine hours a week at each place, but the arrangement is flexible. I punch no time clock.

Ordinarily I'm home for lunch at noon. After that, I have private office hours from 1 to 2:30 and again from 7 to 8. But my only private patients now come from the families of my industrial workers. I see maybe ten or twelve a day on Mondays and Tuesdays, two or three a day the rest of the week. Before long, I expect to cut out evening office hours, call it quits at 5 o'clock.

Leisure vs. Lucre

Afternoons I make a house call or two, maybe drop in to see a hospital patient. Or, if work is light, I just relax with a book or play catch with the kids. Sure, I take it easy. And my coronaries are fine, thanks.

I suppose a hard-working G.P. in private practice nets about 50 per cent more than I do. Not that the same kind of return can't be had in industrial work—if you want to plug hard enough for it. I don't. I may take on one more account, but that will be the limit.

The standard pay rate in my area is $7.50 an hour. Elsewhere, I've heard, it ranges as high as $15, though that may be for a specialist —say, an orthopedist or a man with an interest in occupational pulmonary diseases. In industrial practice, of course, you're also paid for your house calls, emergency calls, and hospital time—and for anyone sent to your private office.

The work has its perquisites, too. My people are mostly machinists, steamfitters, and the like. "If you ever need anything in my line, Doctor, just say the word," they tell me. And several times I have. In the past couple of years, I've acquired a new set of steam pipes, a new roof on my house, and a new ceiling in my waiting room—all for the cost of materials only.

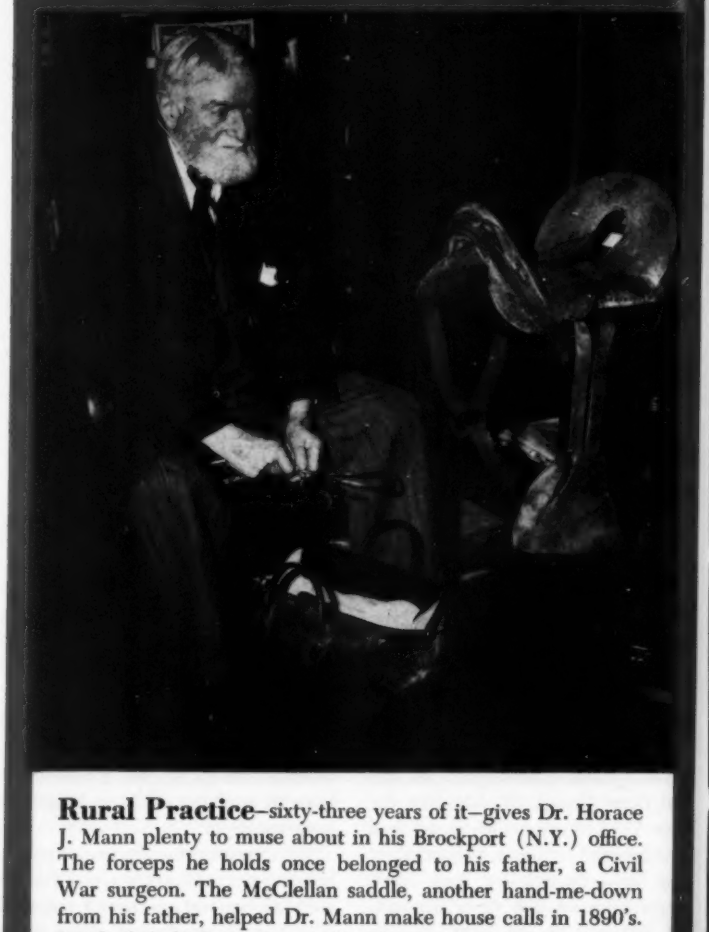
What It Takes

I had no special schooling for industrial work. Nor do I think it's necessary for the average physician who wants to start picking up part-time jobs. Later he may well find it useful to take some post-graduate courses in his particular field of industry.

It's also good to know X-ray work. Most sizable companies have their own X-ray machines and technicians, and it's helpful if you don't have to send out all your films for interpretation.

Other requirements: one or more hospital connections, a sound knowledge of first aid and minor surgery, plus the ability to get along with working people. Perhaps the latter are not so demanding as private patients. But they must be shown the same consideration and courtesy.

—THOMAS F. HIGGINS JR., M. D.



Rural Practice–sixty-three years of it–gives Dr. Horace J. Mann plenty to muse about in his Brockport (N.Y.) office. The forceps he holds once belonged to his father, a Civil War surgeon. The McClellan saddle, another hand-me-down from his father, helped Dr. Mann make house calls in 1890's. Lately he's had to cut out the circuit-riding, but he is still Brockport's health officer. Says a town official: "We just won't let him retire."

Locating More Rural Doctors

Give rural youth incentive to enter medical schools, advises Minnesota dean

• If you want more rural doctors, simply recruit more rural medical students. That's the formula for overcoming the country-doctor shortage offered by Dr. Harold S. Diehl, dean of medical sciences of the University of Minnesota Medical School.

Dr. Diehl's conclusions stem from a study of 545 Minnesota Medical School graduates. The study charted the graduates' present practice locations (all in Minnesota) in relation to the type of community in which they grew up. For tabulation, communities were split into three population groups: (1) under 5,000; (2) 5,000 to 100,000 (not counting Rochester, where the Mayo Clinic brings up a special problem); (3) the three large cities—Minneapolis, St. Paul, and Duluth.

The study showed that almost three out of five medical students from rural areas (population under 5,000) later took up rural practice. Of the students from the three large cities, fewer than one in four went to the country to practice. As Dr. Diehl told delegates to the recent Congress on Medical Education and Licensure in Chicago: "The chances are two and one-half times as great that a medical student [from] a rural community will practice in a rural area as that a medical student [from] a large city will . . . practice in a country location."

The reason for the state's rural shortage, then, isn't that rural medical graduates don't return to the country to practice. It's that the small communities don't provide as many of these graduates as their population warrants. At present, rural areas are the source of 36 per cent of the graduates and are also getting 36 per cent of the doctors back—but such areas contain 51 per cent of the state population.

How to get more rural students into medical school? One way, says Dr. Diehl, would be to give special priority to their applications. "Better still [would be] encouraging and assisting well-qualified young men and young women from rural areas to attend medical school." This would probably involve (1) publicity to interest more rural students (college and pre-college) in medicine; (2) setting up more scholarship and loan funds. END

No, says Frank G. Dickinson, noting how vastly medical progress has increased the M.D.'s capacity for service

• If there's a doctor shortage in the U. S., it's news to the director of the AMA Bureau of Medical Economic Research. In fact, says Frank G. Dickinson, "We are more likely to have a *surplus* of physicians in the Nineteen Sixties than a deficit."

Why? Because of "increase in output" per doctor—caused largely by recent advances in medical technology. Mr. Dickinson estimates that *the average physician renders at least one-third more service today than in 1940.*

Is There Really a

Yes, says Dr. Howard Rusk, warning against a deficit of 22,000 active medical men three years from now

• Immediate expansion and acceleration of medical-school programs —*plus* a greater work load per physician. That's the emergency blueprint for the medical profession drawn by Dr. Howard A. Rusk, chairman of two national advisory committees on mobilization. Purpose: to offset the deficit of 22,000 active doctors he estimates the country will otherwise face by 1954.

Dr. Rusk notes that a substantial deficit in medical manpower is already upon us. He sees no hope of

The reasons he gives for this greater output include:

1. The introduction of "wonder drugs";

2. The expanded use of auxiliary medical personnel;

3. The increase in patients treated in office or hospital, rather than in the home.

The rise in physicians' output becomes even more noticeable, Mr. Dickinson reports, when you look back thirty or forty years. He cites Pike County, Ill., as an example. This rural county in 1920 had one doctor for every 650 persons. Today the physician-population ratio there is 1:1,400—yet the people are getting far better medical care. Witness this incident from the good old days:

Twelve-year-old Mary Johnson had acute appendicitis. The nearest hospital was forty miles from her Griggsville home. It took her father's team of horses a solid hour to plod through the five miles of mud to the railroad station. Another hour was lost waiting for a train. The over-all trip to the hospital took

a Doctor Shortage?

reducing the deficit in the next three years. But by speeding up medical education programs now, he believes, the deficit can be all but wiped out by 1960.

He assumes that the country will be partly or completely mobilized for the next ten years. He also assumes the 1949 doctor-population ratio (one physician for every 850 civilians) should be maintained.

Here, then, are his estimates (in thousands) of the active physicians required for civilian and mobilization needs:

Fields	*1951*	*1954*
Civilian care	178.0	183.7
Military service	17.5	18.5
Civil defense	.6	3.3
Public health	1.6	2.8
Industrial work	.1	1.8
Medical schools	.5	.5
Total	198.3	210.6

According to Dr. Rusk's estimates, the armed forces' demand for physicians will start leveling off after this year. He believes a total of 17,500 medical officers will be needed in 1951 for the authorized 3.5 million troop strength. That's

NO six hours. By the time Mary got there, it was too late.

Today, a child could be driven those forty miles within an hour. But that's not the whole story. Says Mr. Dickinson:

"She might go east to Jacksonville in, say, forty-five minutes. She might even be taken to St. Louis, with its splendid medical facilities, in two hours. Or she might be taken to the forty-three-bed Illini Community Hospital in nearby Pittsfield in ten to fifteen minutes. She'd be far closer to a doctor, in terms of life-saving minutes, than Mary Johnson ever was—even if there were *no* doctor in Griggsville."

As further evidence that there's no shortage, Mr. Dickinson points to three current health records:

(1) Life expectancy is twenty years greater today than it was fifty years ago;

(2) The maternal mortality rate has hit a record low of less than one death per 1,000 live births;

(3) The infant mortality rate is 3 per cent, another new low.

Even supply-and-demand economics, he says, argues against the shortage claim. Physicians' fees have risen only half as fast as the over-all cost of living. "It stands to reason," says Mr. Dickinson, "that this index of physicians' fees . . . would have risen much faster if there had been an alarming shortage of physicians."

Is There Really a Doctor Shortage?

YES a ratio of five doctors per 1,000 servicemen. By 1954, he assumes, the services may have 5 million men in uniform but will be using a 3.7 physician ratio.

Because of mobilization burdens, he predicts a shortage of 22,000 active physicians by 1954—*unless* the present medical-school output (6,000 graduates a year) can be upped. He sees two ways to do this:

1. *By increased medical-school enrollment*—a half-way measure at best. To quote Dr. Rusk: "The increase per class in the last war was 12.5 per cent. Yet even by a 15 per cent enrollment increase over 1949, beginning next September, we would by the summer of 1960 have produced only 5,000 of the needed 22,000."

2. *By acceleration*—"the only logical solution." This would produce an extra 6,000 physicians every three years. By 1960, the gain would mount to 12,000, or more than twice the gain from an enrollment increase. Acceleration also would start producing results two years earlier than would an enrollment increase. Combined, the two measures would act on one another to bring about even further gains.

Admitting drawbacks in any ac-

Straws in the wind like these, he adds, should make educators think twice before stepping up medical-school programs. A serious surplus might result, he believes, from boosting total graduates to a proposed 7,000 in 1960. It would also drain money and brainpower from other vital training programs.

"Are we going to say that there is a shortage of physicians until we have one in every community of more than 100 people? . . . Is there a shortage of medical schools unless *every* qualified candidate can be admitted? . . . (We also need chemists, physicists, elementary and secondary school teachers . . . In fact, physicists and chemists are destined to become almost as important as physicians in protecting the health of Americans in the atomic age.)"

What about the drain of physicians from the home front by the armed forces? Mr. Dickinson thinks their loss can be offset by "stretching" the remaining civilian M. D.'s. In World War II, he points out, only 60 per cent of physicians stayed home to care for the 90 per cent of the population that remained civilians. "What happened? The health of the American people continued to improve."

The fact that so many physicians could be spared to the armed forces, he says, is strong evidence of a surplus of doctors in the early 1940's. He doubts that the surplus has since evaporated. END

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celeration scheme, Dr. Rusk urges profiting from mistakes made in the last war. "The depletion of teachers can be prevented," he says. "Students need not be disturbed by change in their student status. Interneships could be extended rather than curtailed."

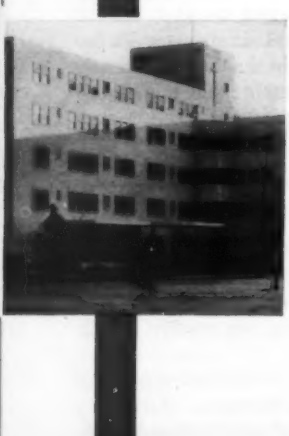
Increased enrollment plus acceleration would not close the gap entirely. There still would be a deficit of about 2,000 doctors in 1960. So "belts will have to be tightened all around, even with such a program."

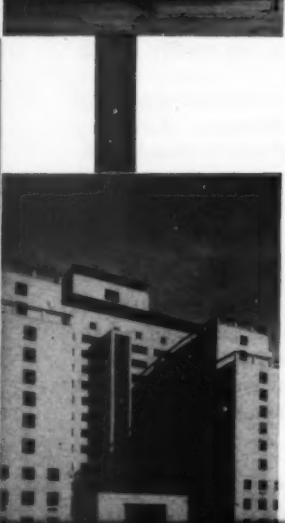
Dr. Rusk adds:

"The plans outlined are flexible. They do not impose a permanent oversupply of physicians . . . If the international situation becomes more favorable, the increased tempo of training can readily be adjusted . . .

"It is the considered opinion of the Health Resources Advisory Committee of the National Security Resources Board that there are but three [courses open to our medical schools]: expand, and/or accelerate, or fail . . ." END

NOTE: *This article reflects the* personal *viewpoints expressed by Dr. Rusk and Mr. Dickinson at the recent Congress on Medical Education and Licensure in Chicago.*





Why Our Hospitals Are in Trouble

● Our voluntary hospitals today are like a patient whom doctors have despaired of saving, but who is unaccountably getting better anyway. Yet what looks like a cure is actually only a remission.

Fortunately, over the long pull, while there is no specific treatment for the disease, the prognosis is not wholly unfavorable. A number of remedies are being tried, and some of the results have been promising, if not dramatic.

The tie that binds the financial outlook of the hospital to the professional outlook of the physician grows constantly stronger. Doctors who practice entirely outside the hospital today are an ever-dwindling fraction of the profession. And to the degree that the medical man depends on the hospital to help him with his practice, he benefits when the hospital is strong and loses when it is weak.

"The doctors need trained and efficient personnel to carry out their orders, and proper facilities for the execution of

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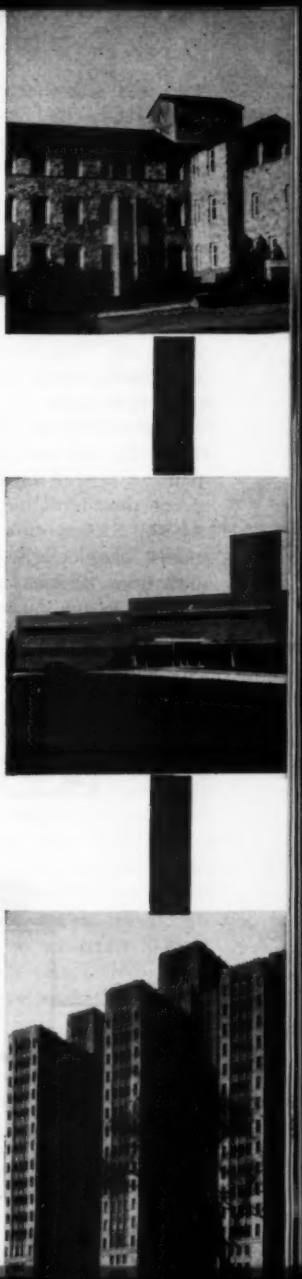
**Robert M. Cunningham Jr., author of this penetrating report, is managing editor of The Modern Hospital.*

Business is booming—yet our voluntary institutions are still dangerously close to the line



such orders," an accounting expert told one hospital board recently. "Both require funds," he pointed out, arguing for an increase in the hospital's rates. Ironically, the increase was opposed by some of the doctors, who foresaw possible objections from their patients.

Whether or not physicians should take an active interest in hospital management, as the AMA's Hess committee suggested in its celebrated report last summer, there is no doubt that hospital-doctor relations would improve if doctors knew more about hospitals' financial problems. While the Hess committee's suggestion was greeted with restrained enthusiasm by hospital administrators and trustees, most of them welcome an opportunity to tell the doctor about their troubles.

The financial position of any hospital results from an intricate combination of factors—costs, occupancy, collections, gifts, the condition of its plant, and earnings on invested funds. But experience in each of these areas is likely to reflect the economic condition of the community.

In prosperous times, hospital costs go up—but so do occupancy and collec-

tions and gifts and earnings. Unquestionably, the recent remission in its financial problems the average voluntary hospital has enjoyed reflects the general prosperity of post-war America. Full employment makes full hospitals.

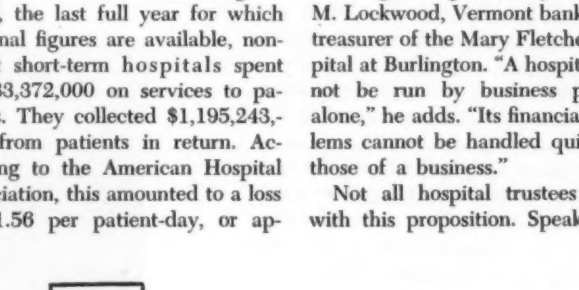
In good times, moreover, hospitals tend to fill from the private rooms down, instead of from the wards up. This has an obviously important bearing on the ratio of receipts to costs.

The ratio itself is revealing. In 1949, the last full year for which national figures are available, nonprofit short-term hospitals spent $1,333,372,000 on services to patients. They collected $1,195,243,000 from patients in return. According to the American Hospital Association, this amounted to a loss of $1.56 per patient-day, or approximately 10 per cent of what it costs to provide a patient-day of care.

Few businessmen would break into cheers over an enterprise that even in a good year loses 10 per cent. But hospital authorities are used to this sort of thing.

"To limit losses, year after year, to amounts approximately equal to recurring contributions and gifts is more difficult, I submit, than to run the usual business corporation whose goal is profit," says William M. Lockwood, Vermont banker and treasurer of the Mary Fletcher Hospital at Burlington. "A hospital cannot be run by business precept alone," he adds. "Its financial problems cannot be handled quite like those of a business."

Not all hospital trustees agree with this proposition. Speaking at



"You may not remember me, Doctor. You passed me off in 1933 as an ovarian cyst."

a meeting of hospital and nursing executives last year, a board member of a large hospital in the Middle West suggested that simple business principles should prevail in the hospital. "Buy the best and charge what you have to in order to make ends meet," he declared.

The nicest thing said about this man afterward was that he had a lot to learn. What about the hospital's charitable responsibilities, the group wanted to know. What about city and county and state welfare cases at below-cost rates? What about "readiness-to-serve" costs and emergency services? What about doctors who run up diagnostic charges on Blue Cross and other flat-rate contract patients? What about costs that leap 50 per cent while patients and doctors are objecting to 10 per cent rate increases? What about the onrush of medical science, with its endless flow of new drugs and technics and machines? What about charges so high that people stay out of private rooms, if not out of hospitals?

The trustee with the charge-what-you-have-to concept of hospital finance isn't the only one who doesn't know the answers.

Hospitals in Black

For many hospitals in recent years, gifts and endowments and subsidies and grants have bridged the gap between operating expenses and revenues. Such "other income" reported by nonprofit short-term hospitals for 1949 amounted to $2.08 per patient-day. Result: These hospitals, despite their $1.56 per patient-day loss, wound up the year 52 cents a patient-day ahead.

But gifts and subsidies won't last forever. And the voluntary hospital structure from which the difficult questions emerge hasn't changed at all.

The essence of the voluntary hospital's financial struggle in our time is that its monk's habit still shows beneath its pin-stripes. Modern business methods have come to the hospital, but society remembers its church and almshouse origin and makes demands that are all but impossible to meet. This is apparent in many ways.

Business or Charity?

Recently the administrators of several hospitals were comparing notes on their collection methods and experience. Most of the hospitals represented in the group were using outside collection agencies on slow accounts and going to court when other measures failed. Yet all the administrators agreed that they would unhesitatingly extend credit again to a patient whose account was delinquent. "The test for admission is the need for service," said one man, his monk's cloth showing plainly. As simply as it can be done, that sums up the difference between the hospital and the market place.

The almshouse concept is re-

sponsible for a common hospital practice that is undoubtedly one of the weirdest things in a weird business—the below-cost ward rate. This is a hangover from the time when hospitals were largely for the sick poor and patients who paid anything at all were on a casual, pay-whatever-you-can basis.

Losing Proposition

The below-cost rate is especially prevalent in the larger eastern hospitals. It is still defended by some administrators as a legitimate form of charity. The fallacy of this view was pointed out recently by Edgar H. Ertel of the Philadelphia Community Chest:

"We may theorize that rates established at less than cost represent the distribution of charitable benefits. But this means there is no distinction in the distribution of benefits between those who need them and those who do not. Is the hospital keeping faith with its contributors when it gives service worth $100 to someone who can readily afford to pay $100, but charges him only $60 on the basis of established rates?"

Probably the most ruinous aspect of the below-cost rate is that it tends to perpetuate one of society's impossible demands on the voluntary hospital: the below-cost payment for indigent patients who are public charges.

The latest comprehensive survey of payments for indigent care by city, county, and state welfare agencies showed that hospitals were collecting only about 60 per cent of the cost of caring for these patients. In one state, the average welfare payment ($4.20 a day) was just 25 per cent of the average cost of a day's care. Efforts to get indigent payments increased have often failed because welfare officials could point to published ward rates lower than the cost figure the hospital was asking for.

Obviously, the below-cost indigent payment hurts most when the hospital is caring for a large number of public charges. It is plain that this is one of the major contributing causes of hospital insolvency.

In some hospitals, the situation is desperate. "The story of things here is an unfortunate one, because there is nothing seriously wrong with this hospital, its medical staff, or its board," an administrator wrote to a friend, explaining that he was looking for another job. "The future looks good except for one thing: We are losing terrific sums every year on the hospitalization of indigent and medically indigent patients, and I cannot seem to inspire the board to conduct the crusade that is necessary to get adequate payments.

"Our per diem costs are well over $15, and the per diem payment we received for indigents last year figured out at $4.96. Since about 25 per cent of our patient-days are those of indigent and medically indigent, we lost over

$80,000 in this 120-bed hospital.

"We have made our pharmacy a real money-making department, converted ward space to semi-private, and done a dozen other things to help the situation. But it has all been too little and too late. As long as you sell one-fourth of

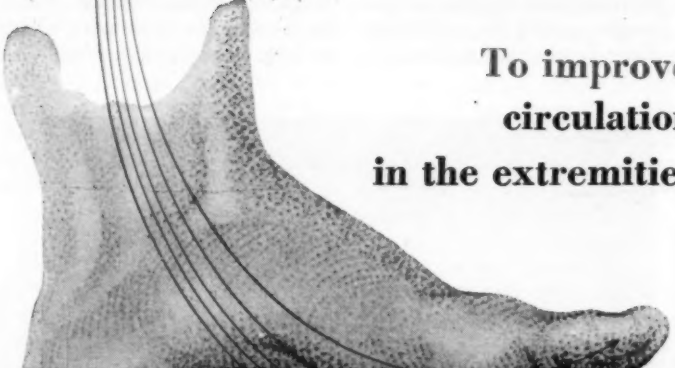
RODEOLOGIST

• Though he was 35 before he ever even sat a horse, Dr. Lane Falk, now 49, averages $5,000 in rodeo prizes each summer, competing only on week-ends.

The picture shows him, "piggin' string" in teeth, about to throw and truss his animal in a calf-roping contest. "But I do more team steer-roping nowadays," he says, explaining that steers are merely roped, not thrown. "Wrestling calfs left my hands stiff for Monday operations."

With more than 100 first-place awards since 1938, and a 1945 team-roping world's championship to his credit, the Modesto, Calif., surgeon ranks among the top third of the nation's rodeo ropers. Off season, he breaks colts at his horse ranch.

Though he suffered a broken shoulder in a rodeo event a few years ago, he plans to go right on with his lariat-swinging in some twenty-five cowboy jamborees a year. Ropers, he says, usually keep their touch well into their sixties. END



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your product for less than one-third the cost of production, you are bound to have trouble."

Fortunately, other administrators have been more successful in getting their boards to act in the matter of indigent payments. Taking over the presidency of a hospital in Wisconsin, a new trustee looked at the hospital's financial statement, then promptly addressed a letter to the welfare department. "Apparently a misunderstanding has existed for some time," he wrote. "Rates and charges are determined by the properly constituted authorities of the hospital; as of today, any discounts that your department has been receiving may be considered discontinued. From this day forward the rates and charges applicable to your department will be the regular scheduled rates and charges of the hospital. All future admissions from your department will be on this basis."

While such headlong action may do no more than transfer the discount load to some other hospital in the area, this board president's letter does indicate awareness that the problem is a critical one. This is a hopeful sign in itself, considering the years the problem existed unrecognized. The hospital that is forced to take losses on its welfare patients must either go broke or get the money from some other source. Usually, it increases its rates to paying patients, thereby accomplishing an unsound and illogical transfer of the indigent burden from the taxpayers to the sick.

Happily, the sick in ever-increasing numbers are joining hands with the well to carry the heavy end of the pole. An estimated 70 million people are now protected by some form of hospitalization insurance, nearly two-thirds of them by Blue Cross. In most cities, one-fourth to one-third of all hospital patients hold Blue Cross cards. Some hospitals now report that three-quarters of all incoming patients are insured—a circumstance whose beneficent effect on the hospital's financial stability is hard to overestimate. The most expensive bed in any hospital is the empty one, and the patient with Blue Cross is a lot less likely to resist when the doctor suggests hospitalization. Blue Cross has also filled thousands of semi-private beds with patients who would otherwise have been in wards. And to whatever extent Blue Cross has been sold among low-income groups, the medical-indigent burden on the community—and on the hospital—has been relieved.

Fictitious Figure

These benefits, however, are unmeasurable; the Blue Cross patient who would have stayed home doesn't appear on the hospital balance sheet. What often *does* appear there is an item called "Losses on Blue Cross"—a sum representing the difference between the aggregate of Blue Cross payments to the hospital and the aggregate of hos-

pital charges at regular rates for all services rendered to Blue Cross members.

But this loss figure is actually an intangible "might-have-been," while the elusive patient whom Blue Cross brought to the hospital is pouring real money into the till. Failure to see this has caused many hospital administrators and trustees to take an unreasonably dim view of Blue Cross. Failure to *make* them see it has caused many Blue Cross executives to cry out at night. Both failures have held up Blue Cross progress, thus contributing to the financial woes the two groups are trying to soothe.

How Doctors Hinder

While hospital and Blue Cross people often glare at each other across the balance sheet, they become kissing cousins when the doctor enters the room. Far too frequently, they charge, doctors look on Blue Cross as a natural enemy and regard evasion of its rules as a sporting proposition, like beating the income tax. Such doctors, they say, load Blue Cross bills with charges for all sorts of service that isn't really necessary. This is a burden to the hospital if Blue Cross payments are on a flat rate per diem, as many are. It's a burden to the plan if Blue Cross pays the hospital's regular billing, as some do.

In either case, it is a burden to the community. Unnecessary hospital service is a form of conspicuous waste that makes economists shudder. In one city (Chicago) the problem had become serious enough a few months ago for Blue Cross to organize a public relations program aimed at teaching doctors the fiscal facts of hospital and Blue Cross life.

There and elsewhere, however, it will take more than "Dear Doctor" letters to establish hospital care on a financial footing sound enough to assure the future of the voluntary system. The first line of attack has generally been the individual hospital's effort to stop, or at least curb, the wild upward spiral of hospital costs.

Of course, costs that rise in response to economic pressures *outside* the hospital can't be controlled from *inside* the hospital. But the general inflationary trend does not wholly account for such cost increases as that reported recently by the United Hospital Fund of New York. The cost of ward care in New York voluntary hospitals in 1940 was $6.33; in 1951 it is $15.86, an increase of more than 150 per cent.

For all voluntary short-term U. S. hospitals, the cost increase came to more than 50 per cent in four years—from $10.04 per patient-day in 1946 to $15.14 in 1949.

If these figures weren't so bad, they might lend credibility to the widespread notion, shared by many doctors, that hospitals are inefficient. Obviously, however, the dif-

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ference between the most and least efficient operation could account for only a fraction of today's huge hospital costs.

"No store can give away half its goods and expect to break even by using less wrapping paper," is the way Dr. Basil C. MacLean of Rochester, N. Y., sums it up.

New Gimmicks

Nevertheless, most hospitals are making a valiant effort to keep the lid on. A hospital in Salt Lake City recently made an exhaustive job analysis of its nursing service. The result was a "downgrading" of many nursing duties to aides and attendants drawing less pay than nurses—a real payroll economy. Similar studies are going on in all departments of many hospitals all over the country.

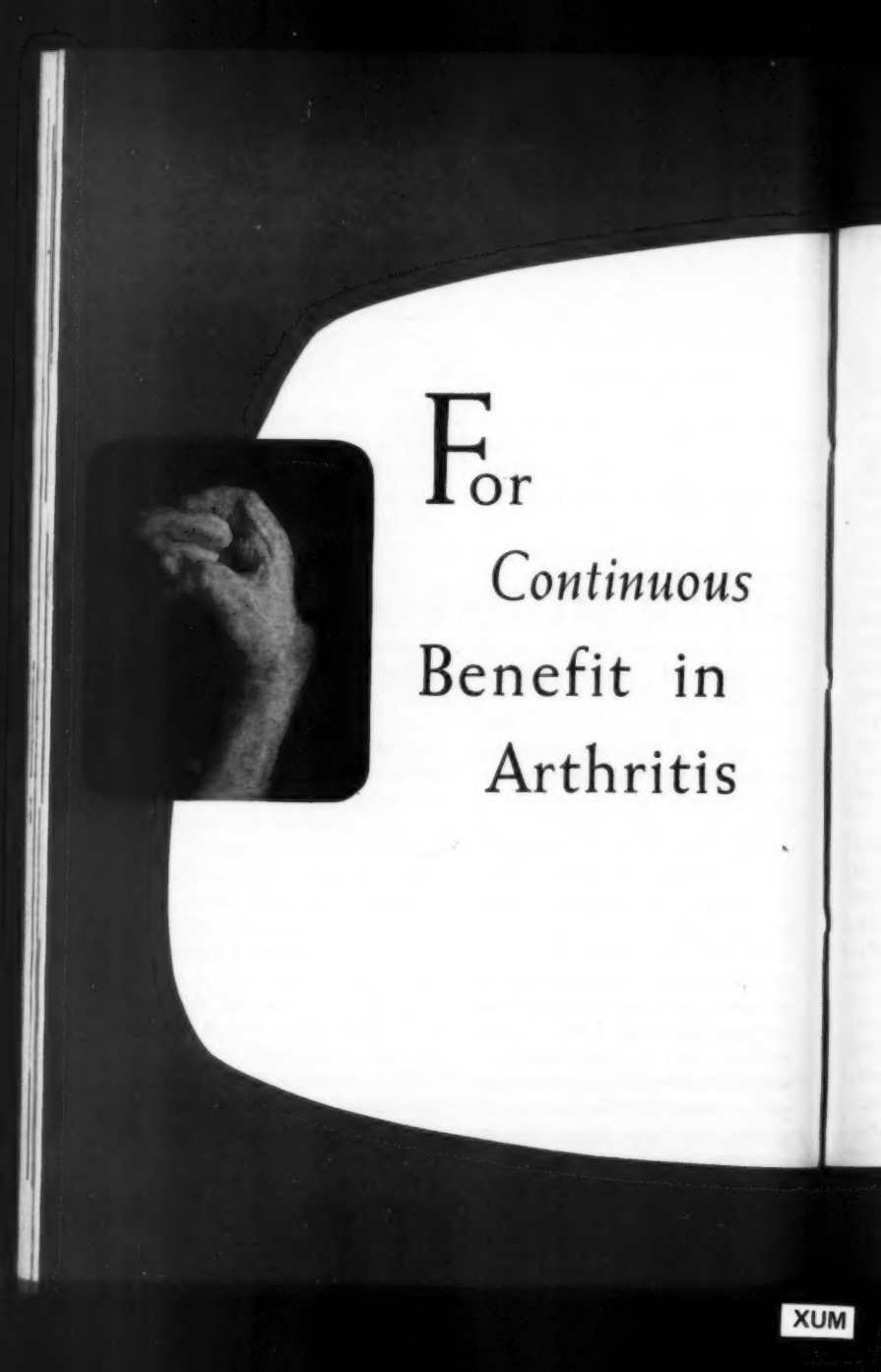
Because 60 cents of the hospital dollar is paid out in wages, studies everywhere aim at reducing personnel turnover and at saving time and motion. In its training program for housekeeping help, a hospital at Racine, Wis., uses life-size photographs to demonstrate right and wrong ways to wash floors and windows. A hospital in Chicago has employed an industrial psychologist to teach supervisory personnel how to make workers want to work harder. A hospital in Boston is experimenting with a "roomette" designed so the patient can help himself to the maximum extent and economize on nursing time. Everywhere, labor-saving machines are being introduced to clean walls, wash dishes, keep records.

Hospitals today are also lighting up their fiscal practices with modern cost-accounting methods. Simple cash accounting—a holdover from the days when Mr. Rich paid most of the bills and anything collected from patients was lagniappe—is giving way to the accrual method of accounting. Only when earnings for all services are accrued at established rates, whether or not they are actually paid for at those rates, can the hospital get a true picture of its operations.

"The financial problems of hospitals arise chiefly from the fact that, contrary to general business procedure, a large portion of their product is given away," C. Rufus Rorem, a hospital accounting authority, said recently. "The knowledge of *how much* is given away, and to whom, is essential to good management."

That knowledge is certainly essential to good rate-making. Gradually, accurate departmental accounting is bringing about adjustment of the below-cost rate and of the loss on indigents. Ultimately, it may point the way out of another hospital puzzle: the rate that bears no relation to cost but is "loaded" to cover other losses.

This practice has special interest for doctors. In part, at least, the hassle between hospitals and specialists is fiscal as well as professional. The truth of the specialist's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The many hundreds of cases investigated, the follow-up studies after periods of five, ten or more years, the thousands of cases benefited in daily practice—these testify to the clinical efficacy of ERTRON over an extended period.

In a high percentage of cases ERTRON has been found to give relief from pain and the distressing symptoms of the arthritic syndrome.

Prescribe ERTRON—the Steroid Complex with the extensive bibliographic background covering a fifteen-year period.

ERTRON is a potent drug and, like all potent drugs, should be administered only under the direction of the physician who will determine proper dosage levels for the individual patient.

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DIVISION NUTRITION RESEARCH LABORATORIES, INC. • CHICAGO 11, ILL.

charge of "exploitation" and the hospital's counter-charge of "monopoly" cannot be determined wholly by accounting, perhaps; but it can't be determined at all *without* accounting.

As Dr. Fred Carter of St. Luke's Hospital in Cleveland observed not long ago, "For a great many years, we have slowly but thoroughly been scrambling an egg. Now we are suddenly confronted with the job of unscrambling it and getting it back into the yolk and white stages. That is a large order."

Signs of Progress

Probably the most encouraging of all efforts to unscramble the egg are *group* efforts. Like miners in a union hall and debutantes at a cotillion, hospitals make a better showing in groups than they do alone. The greatest progress in obtaining adequate payment for indigent patients has been made by hospital associations, not by hospitals.

In Connecticut, for example, the state hospital association a year ago got a 100 per cent increase in payments for state cases. Starting in July this year, Connecticut's voluntary hospitals will get cost payment for indigents—the ultimate goal, attained by carefully prepared, factual statements of the hospital case.

Under new legislation in Virginia, hospitals are entitled to an adequate cost payment for certified indigents through state aid to local welfare departments. In some areas the need outstrips the appropriation, so Virginia hospitals are still carrying part of the burden. In Maine and California, state associations have taken the hospital story to the public in effective public relations programs that foretell better times.

Coming Salvation

Coming up on the hospital horizon is another form of group action that some economists see as the salvation of the hospital system: the coordinated regional service. For years, there have been a few regional plans under which radiology, pathology, and other special services, are shared by groups of hospitals. The Bingham plan in Maine has successfully helped small hospitals there to provide good service at low cost. The Kellogg Foundation has been working with hospitals in Michigan toward integration of services that are too expensive for the small hospital to carry on unaided.

Other special-purpose programs have had try-outs. Small hospitals in the area of Rochester, N. Y., get internes in a regional teaching lottery. The New York University-Bellevue Medical Center also has a farming-out plan for medical teaching in a group of small outlying hospitals. Group purchasing plans have been tried in New York, Philadelphia, Cleveland, Chicago, and other cities, with moderate success.

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ORETON supplies androgen to rehabilitate the climacteric or eunuchoid patient.

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ORETON overcomes excessive estrogen activity, and controls functional uterine bleeding and dysmenorrhea. ORETON exerts a palliative effect in carcinoma of the breast.

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ORETON, Schering's brand of Testosterone Propionate U.S.P. in oil for intramuscular injection.

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AND *softness*
ARE ESSENTIAL IN
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KONDREMUL, being finely subdivided, contributes soft bulk to the dry fecal residue, easing elimination and encouraging regular bowel habits.

KONDREMUL Plain (containing 55% mineral oil).
KONDREMUL with non-bitter Extract of Cascara (4.42 Gm. per 100 cc.)
KONDREMUL with Phenolphthalein—.13 Gm. (2.2 grs.) per tablespoonful.

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AN EMULSION OF MINERAL OIL AND IRISH MOSS

Also in tablet form
KONDRETABS

—the original Irish Moss—Methyl Cellulose Bulk Laxative in Tablet Form.

KONDRETABS induce soft, easily eliminated bulk—no bloating, griping, impaction. Convenient, pleasant, easy to take.

THE E. L. PATCH COMPANY
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ordinated service has recently been proposed for hospitals in the Minneapolis-St. Paul area. Based on a survey made by James A. Hamilton of the University of Minnesota, this plan would consolidate nineteen Twin-City hospitals into four medical-center groups. Medical services would be integrated within these groups. Such operations as purchasing, laundry, record-keeping, and administration would be pooled.

Hamilton has estimated that the plan would save $22 million a year in hospital expenditures for the whole area and deliver better service than the people are getting now. The inevitable loss of autonomy it would involve has caused many doctors and hospital administrators to back hastily away. But the boards of twelve of the hospitals have agreed to go ahead with further exploratory meetings, at least.

If Hospitals Merge

The case for coordination of hospital facilities has been presented in more detail in Minneapolis than anywhere else, but it is increasingly recognized as a path to the stabilized hospital economy everyone seeks.

"Bed occupancy of hospitals ranges up to 90 per cent of capacity. But it is not uncommon to find expensive scientific apparatus used less than two or three hours out of twenty-four. Substantial savings to the community could be achieved through joint utilization of specialized facilities and personnel." So says J. Hamilton Cheston, president of the Philadelphia Saving Fund Society and a hospital trustee, who then adds:

"In some cases, a small hospital can serve the community best as a special department of a large institution. In other cases, the public interest would be served best if complete mergers of institutions were accomplished. Such coordination is often strongly resisted by members of governing boards or attending staffs of the various hospitals. But the time has undeniably come when the community should insist on such action as may be in the best interest of the patient and those who support the hospitals financially."

The Doctors Object

Doctors who abhor talk about integration and mergers as a threat to their independence can take comfort in the knowledge that the fully coordinated service will come slowly, if it comes at all. More than half the 1,500 Hill-Burton projects approved so far have been hospitals of fifty beds or less. The small community's insistence on having its own hospital puts a brake on the kind of regional integration medical theorists have been dreaming about.

But it doesn't call a halt to all inter-hospital cooperation. Shared specialist services are here to stay. Many small hospitals are reaching for economies through cooperative

Psychoneurotic Women of Genius

Isadora Duncan, renowned American dancer, was admired throughout the world for her creative ideas and graceful artistry, but estranged her native public through her psychoneurotic eccentricities.

The majority of psychoneurotics have no serious mental illness, but display merely an emotional imbalance which often can be greatly improved by appropriate psychotherapeutic and sedative management. In the treatment of psychoneurosis, particularly agitated, depressed and anxiety states, Mebaral is especially useful when tranquillity with minimal hypnotic action is desired. Sedative dose: Adults, from 32 mg. to 0.1 Gm. (½ to 1½ grains) three or four times daily. Children, from 16 to 32 mg. (¼ to ½ grain) three or four times daily. Supplied in tablets of 32 mg., 0.1 Gm. and 0.2 Gm.

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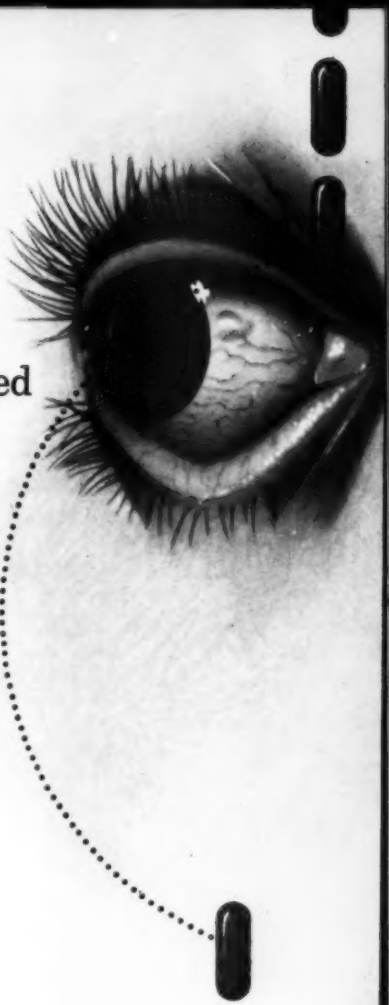

Vitamin deficiencies can rarely be diagnosed from the textbook[1]...

...or from their classical symptomatology. For example, corneal invasions may arise from a riboflavin deficiency, or a deficiency of vitamin A may be indicated. Patients suspected of having two or three deficiencies show improvement only to a certain point when given the two or three specific vitamins.[1] In such instances, multiple vitamin therapy is indicated.

THERAGRAN —Therapeutic Formula Vitamin Capsules Squibb—supplies clinically proved, truly therapeutic dosages of all the individual vitamins indicated in mixed vitamin therapy.

1. Spies, T. D., and Butt, H. R., in Duncan, G. G.: Diseases of Metabolism, ed. 2, Philadelphia, W. B. Saunders Co., 1947, pp. 485-496.

Each Theragran Capsule contains:

Vitamin A	25,000 U.S.P. units
Vitamin D	1,000 U.S.P. units
Thiamine HCl	10 mg.
Riboflavin	5 mg.
Niacinamide	150 mg.
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Bottles of 30, 100 and 1,000.

Whether lesions be acute or chronic... mild or severe— for truly therapeutic dosages

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THERAPEUTIC FORMULA VITAMIN CAPSULES SQUIBB

A single vitamin deficiency may veil many.

Syndromes produced by lack of a single vitamin rarely exist in medicine. Spies and Butt[1] insist that even "where there are clear evidences of one deficiency there must certainly be some signs, perhaps veiled, of other specific deficiency states."

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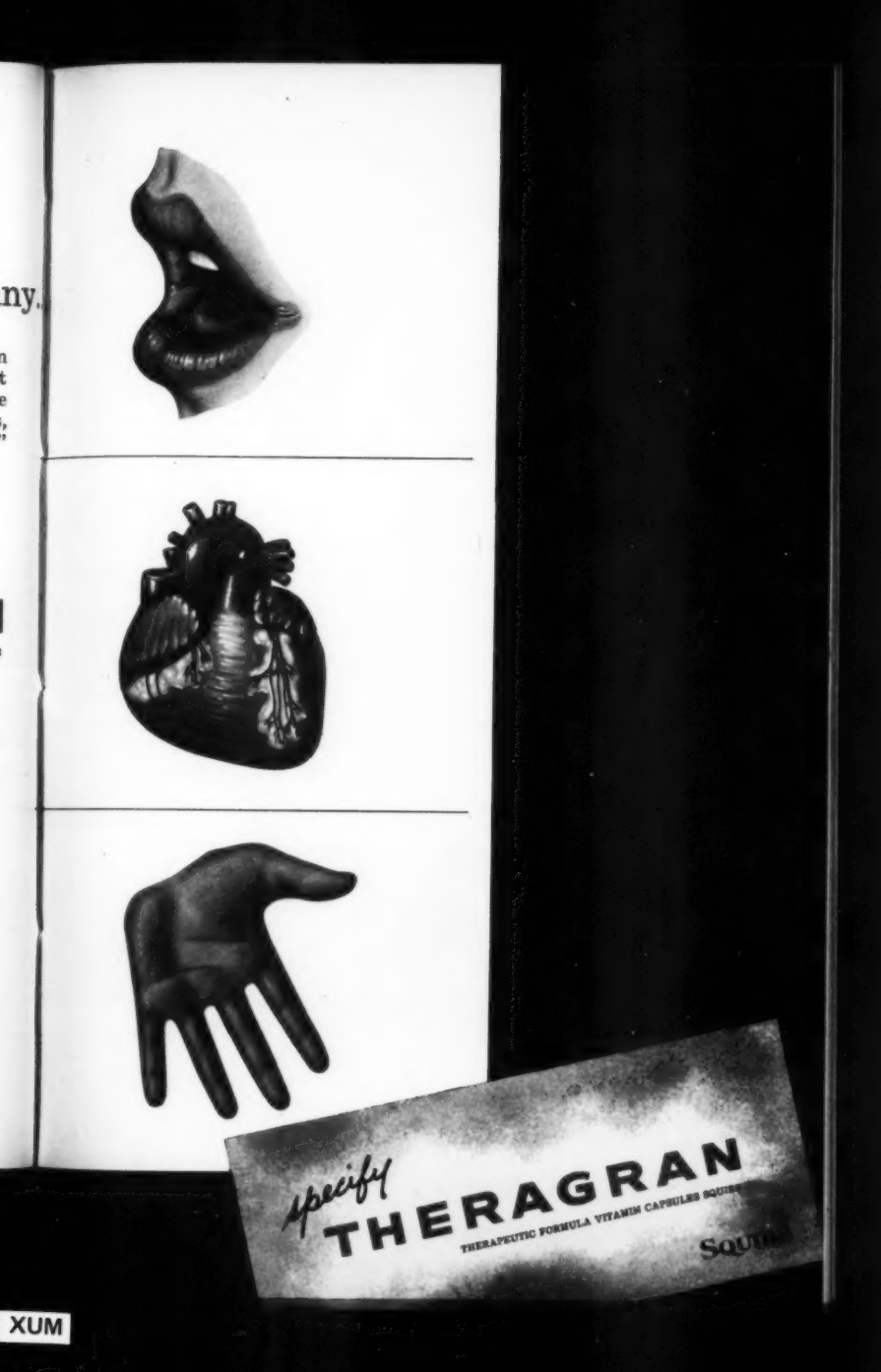
1. Spies, T. D., and Butt, H. R., in Duncan, G. G.: Diseases of Metabolism, ed. 2, Philadelphia, W. B. Saunders Co., 1947, pp. 485-496.
2. Jolliffe, N., in Jolliffe, Tisdale & Cannon: Clinical Nutrition, New York, Hoeber, 1950, pp. 634, 23-24.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Mild acute

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Thiamine HCl	10 mg.
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for truly therapeutic dosages . . .

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plans for part-time service of dietitians, record librarians, physical therapists, accountants, and other technical and administrative experts.

Whether or not all these economies will add up to hospital care at a price the public can afford is the big unanswered question in hospital economics today. Through Hill-Burton legislation, the taxpayer has been introduced to the voluntary hospital. He has become a substitute for the vanishing philanthropist. So far, the taxpayer's interest has been just as benign as the philanthropist's was. But there are possibilities of financial collapse that could bring the taxpayer into the business as a full partner.

One of these is runaway inflation that would empty beds and send costs and accounts receivable soaring in spite of all improved business methods. Another is war involving the civilian population to an extent that would fill hospitals with casualties and make them dependent on Government payments.

Another is the continued draining off of doctors, nurses, and other hospital personnel into the swelling Veterans Administration hospital system. Another is the completely controlled economy that might result from a war or defense emergency and bring on compulsory health insurance.

Finally, there is the real and present danger that the public may get caught in the crossfire between embattled doctors and hospitals and call in the police or the Government to settle the dispute.

Opposing these awful possibilities are the simple virtues of individual initiative, community pride, and the spirit of self-sacrifice that most American doctors and hospital people have always shown when summoned in an emergency.

What Doctors Can Do

Before the financial emergency of the voluntary hospital system is finally settled, both groups may be called on for more of this spirit than they have been showing each other in recent years. Hospitals will not close. Either they will make their own way financially or they will ask for and get the kind of Government aid that nobody really wants them to have.

A few doctors have said in anger or exasperation that they would rather have socialized medicine than "lay domination by hospital boards." Fortunately, the majority understand that this isn't the alternative. The choice today is not between socialized medicine and lay domination. Instead, it is between (1) the entering wedge of Government subsidy and (2) the kind of doctor-hospital cooperation, including some sacrifice of independence on both sides, that will give voluntary hospitals the long-range financial stability they must have to survive.

To a larger extent than many of them realize, it's the doctors' choice.

—ROBERT M. CUNNINGHAM JR.

Mrs. Fitzhugh is eating for two...

Twice as much starch as before

Her diet's substantial

But foods deemed essential

Are those she'd prefer to ignore

IF you suspect any of your OB patients of follow in Mrs. F's footsteps—or if you have any do about adequate intake of essential minerals and v mins—why not prescribe 3 to 6 DICALDIMIN capsu daily as a supplement? Only three of these provi

- Liberal amounts of calcium and phosphorus.
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Doctors Plan Inter-City Defense

Your CD work will be cut out for you even if you're not in a prime target area

• One of the big question marks in civil defense is *not* how well cities like Elmira, N.Y., and Canton, Ohio, can take care of *themselves*. It's how fast these communities can get their medical teams and supplies to Rochester or Cleveland—prime targets 50 to 150 miles away.

The reasons for a rising interest in inter-city assistance are obvious:

1. Medical facilities tend to be concentrated in prime target areas. Virtual annihilation of the medical and nursing profession locally could result from a mid-day burst. This must be planned for.

2. One atomic bomb on one target city could produce a volume of injuries requiring one-third of all doctors and nurses in the average state—at once. So nearly all medical help within a radius of 150 miles might have to be summoned.

Which means that no matter how safe *your* home town may be, you will probably do medical disaster duty if *any* city within a three-hour drive gets bombed.

That's the way New York State CD officials are planning today. Their thinking is getting tougher, simpler, more realistic. It's taken them a couple of years to come around to this viewpoint. But chances are good that their current ideas will bulk large in the CD pattern of the rest of the country.

Says Dr. James Lade, New York State's CD medical director: "Every target city in the state must send medical personnel and supplies if any one city is attached. Needless to say, that goes double for the non-target areas."

But wouldn't that leave them stripped of health personnel, unprotected in case of a second attack? The answer: "That's the way it must be. There is no hope of adequate medical care for the injured without all-out response of physicians in neighboring communities."

You can visualize what would happen—like this:

A soap opera in full cry is interrupted for a news flash: "This is an official announcement. An atomic bomb has fallen on Rochester!" The word filters down to Dr. Harold Hollander, a G.P. in Binghamton, N.Y., about a hundred miles to the southeast. He sends his patients home, goes straight to his local CD assembly point. [*Turn page*]

simplified

diabetic management through improved time-action and fewer injections

NPH ILETIN (INSULIN, LILLY)

For many diabetics taking two or more daily injections of other Insulin preparations, one daily injection of NPH Insulin will often be adequate for purposes of control. This improvement is a long stride toward a more nearly normal life.

For physicians, this development eliminates some of the obstacles which earlier stood in the way of satisfactory adjustment of doses to the patient's needs.

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Detailed information and literature concerning NPH Iletin (Insulin, Lilly) are personally supplied by your Lilly medical service representative or may be obtained by writing to

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There, buses are being loaded with emergency supplies. As soon as four or five doctors and voluntary lay personnel board one bus, they're off—to an assignment depot on Rochester's south edge.

Once in the bombed city, Dr. Hollander may be directed to a first-aid unit. Or, if he's skilled in major surgery, he may help man one of the emergency hospital teams being set up within a thirty-mile radius of the devastated area. But assignment must be flexible, and he may even end up as a hospital-train doctor, giving supportive treatment to casualties being moved out of the area.

Towns thirty to fifty miles from the attacked city will send in every doctor, nurse, and lay volunteer. Towns from fifty to a hundred miles out will contribute most of their doctors and nurses. Towns more than a hundred miles off may send doctors only. All these M.D.'s will leave behind them barely enough medical manpower to handle the life-and-death emergencies of their communities.

Dr. Hollander may be back in Binghamton the next day with evacuated casualties. Then again, he may be gone a week or more. It all depends on how quickly the injured can be shipped out and on how many relief doctors show up.

Before he's ready for this ordeal, he has a few questions. Some are answerable at this time, some are not:

Who picks the doctors to go or stay? The medical society does this in advance, on instructions from the state CD director. Probably retired or partly disabled M.D.'s will remain at home—but the decision will be made locally.

What happens to his patients when the doctor takes off? They'll have to shift for themselves, calling for medical care only if it's urgent. Such calls will funnel through a central hospital, where a supervising nurse will screen each request. All citizens will be briefed beforehand on this procedure—by the local medical society or CD office.

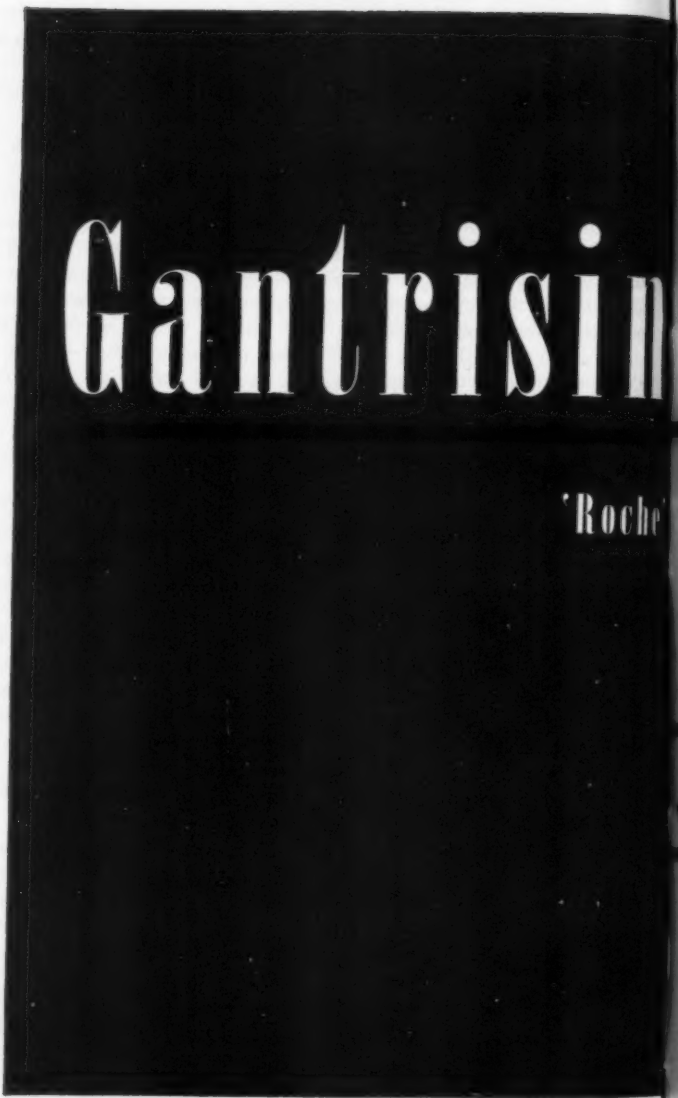
Who will pay for the doctor's time on disaster duty? No one knows yet—but temporary economic chaos is a likely bet.

What if he's hurt or disabled on disaster duty? He'll be compensated for it, probably under a modification of Workmen's Compensation rules.

Should a doctor stockpile supplies in his own office? To a reasonable extent, yes. But CD officials emphasize that he can also do a great deal with whatever equipment he has on hand—and will have to until official medical stockpiles are built up.

The inter-city assistance plan is no polished gem. But if the worst happens, it will help CD people make the best of it. At the moment, however, their feelings are summed up in one stark statement by the New York State CD Commission:

"Optimism is not permissible in planning for medical aid." END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Gantrisin is a sulfonamide so soluble that there is no danger of renal blocking and no need for alkalinization.

■ **higher blood level**

Gantrisin not only produces a higher blood level but also provides a wider antibacterial spectrum.

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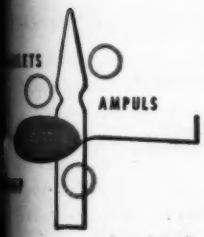
Gantrisin is far more economical than antibiotics and triple sulfonamides.



■ **less sensitization**

Gantrisin is a single drug—not a mixture of several sulfonamides—so that there is less likelihood of sensitization.

GANTRISIN®—brand of sulfisoxazole
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Sugar coating is one reason for the superiority of Tablets MERCUHYDRIN with Ascorbic Acid.

Maximum absorption of mercury occurs in the stomach and duodenum—too high for enteric-coated tablets. But poorly tolerated oral mercurials *must be* enteric-coated. Only well-tolerated Tablets MERCUHYDRIN with Ascorbic Acid can be sugar-coated . . . give consistently greater diuresis with less mercury.

For dependable diuresis and minimal side effects prescribe

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The simplest method of outpatient maintenance

dosage: One or two tablets daily, morning or evening, preferably after meals.

available: Bottles of 100 simple sugar-coated tablets each containing meralluride 60 mg. (equivalent to 19.5 mg. of mercury) and ascorbic acid 100 mg.

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M-15

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Doctors' Offices in Hospitals

How one medical staff uses hospital rooms but retains its professional freedom

• Is the M.D. with office space in a hospital committing himself to an eventual employe status? The staff members of Columbia Hospital, a 160-bed voluntary institution in Milwaukee, don't think so. And they should know. They've had four years' successful experience with their Physicians' Service Department—a hospital-office arrangement that was started at their own request.

Under this plan, staff physicians may meet private patients in any of the department's unassigned rooms. "There are no doctors' offices in the broad sense of the term," says Administrator Joseph G. Norby; "there are merely examining or treatment rooms. No doctor is permitted to have his *regular* office in the hospital."

The department consists of six examining rooms, one waiting room, and one central station. The staff includes two nurses and a clerk. The rooms are equipped simply, but special equipment may be had for the asking from a central supply department across the corridor. All hospital equipment is thus available to the physician.

Patients treated in the department are not entered in the hospital's in-patient or out-patient records. This, it is felt, helps guarantee the doctors' independence. Another safeguard: Doctors do not keep regular office hours here; patients are seen by appointment only.

$1 Per Patient

The hospital runs the department at cost, levies a $1 charge on each patient examined or treated in one of the offices. This charge is kept entirely separate from the doctor's fee.

While providing offices for staff physicians, the department is also the hub of the hospital's emergency service. After first aid has been given an emergency case, the patient's family doctor is notified. He takes over from there.

Staff doctors, selected from a list of volunteers, step in only when no family doctor is available. Follow-ups on emergency cases aren't handled at the hospital, except on the request of the family M.D. The hospital, by the way, makes sure that adequate charges are made for

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POTENT—Alhydrox increases the antigenicity of Dip-Pert-Tet. It helps build maximum, durable immunity simultaneously against Diptheria, Pertussis, Tetanus. Each basic immunization course contains the high pertussis count of 45,000 million Phase 1 H. pertussis organisms. In actual use as well as reported clinical studies[1] it has been shown that Dip-Pert-Tet Alhydrox produces uniformly superior levels of serum antitoxins.

PURIFIED—Dip-Pert-Tet Alhydrox reduces reaction frequency. Try it – compare it in your own practice. You will see that undesirable reactions are reduced to a minimum with purified Dip-Pert-Tet Alhydrox.

Put Dip-Pert-Tet Alhydrox in your pediatric picture. You can depend on it for simultaneous immunization against Diptheria, Pertussis, Tetanus. *Cutter Laboratories, Berkeley, California*—Producers of famous purified Dip-Pert-Tet Plain, a product of choice for immunizing older children and adults.

†*Dip-Pert-Tet Alhydrox*—*Purified Diptheria and Tetanus Toxoids and Pertussis Vaccine combined, Aluminum Hydroxide adsorbed.*

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A FIRST NAME IN COMBINED TOXOIDS

[1]References on request

Cutter Laboratories, Berkeley, California.

emergency care. Aim: to forestall talk that it dispenses cut-rate treatment.

What are the over-all advantages of the Columbia Hospital plan? One participant sums them up this way:

"Besides giving more adequate service to the people, the Physicians' Service Department allows cooperative use of personnel and equipment. It has the advantages of group practice without the disadvantages. It promotes economies that ultimately lower the cost of medical care. And by providing an emergency service for the community, it does a public relations job whose value can't be overestimated." END

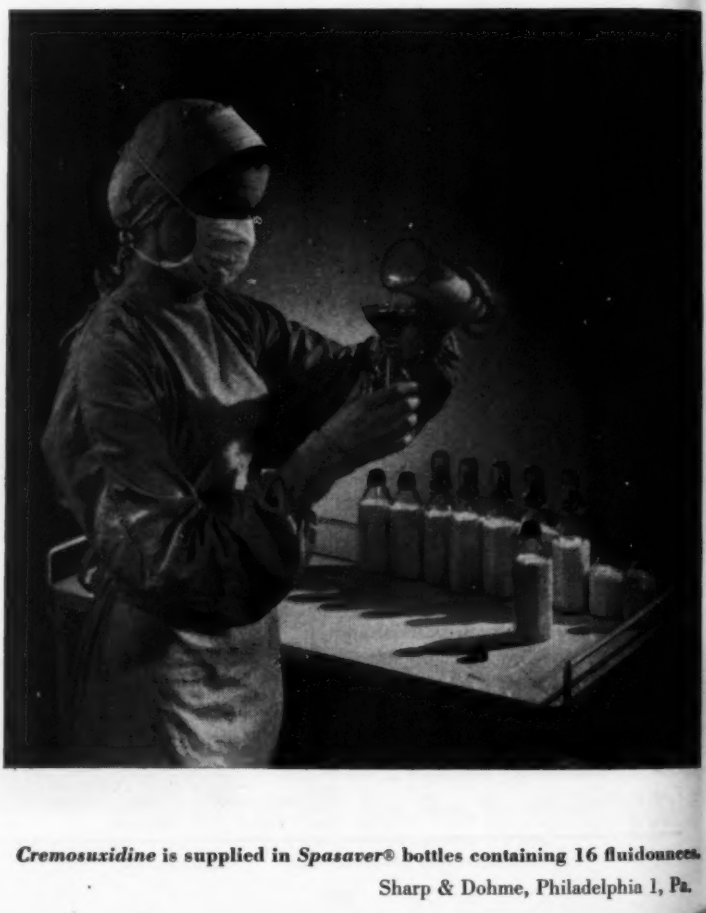
CLINICIAN

• Ground-breaking later this year for the new $4 million home of New York Infirmary's Kate Depew Strang Cancer Prevention Clinic will be as much a tribute to the efforts of Dr. Elise Strang L'Esperance as to the memory of her mother, for whom it is named.

In 1910 Dr. L'Esperance quit a burgeoning pediatrics practice to become assistant to the late, famed cancer authority James Ewing, remained his "shadow" for the next third of a century. She and her sister (nieces of financier Chauncey Depew) founded the clinic in 1937, after cancer had claimed their mother. Three years later, a second Strang Clinic was set up at Manhattan's Memorial Hospital. The two clinics have since served as prototypes for some 250 others here and abroad.

Dr. L'Esperance, now past 70 and an emeritus professor at Cornell, still sparks the Strang Clinics' activities. The new building at New York Infirmary, she estimates, will cut patients' waiting time for appointments from seven months to three. END

triple treatment



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Sharp & Dohme, Philadelphia 1, Pa.

Diarrhea

for specific and nonspecific DIARRHEA

Nuisance, Menace

Diarrhea is a nuisance, "one of the commonest symptoms of illness in the human race,"* *and a real menace,* accounting for nearly 1 per cent of deaths reported in the United States in 1946. *In ten Southern states,* in 1946, more deaths were reported due to diarrhea than to typhoid fever and scarlet fever, pertussis, diphtheria, malaria, measles, and poliomyelitis combined!*

*Southern Med. J.; 43:320, April, 1950

Effective, Convenient Triad

Cremosuxidine® offers a palatably flavored, exceptionally effective triad for control of specific and nonspecific diarrheas: potently bacteriostatic, relatively nontoxic *Sulfasuxidine*®, detoxicant *pectin*, and protective, adsorbent *kaolin*.

Cremosuxidine may be administered for bacillary dysentery, paradysentery, salmonellosis, diarrhea of the newborn, and so-called "summer complaint."

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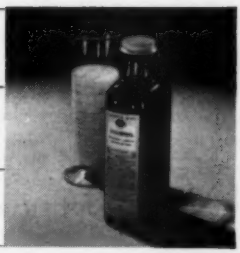


What the Legion Wants From Medicine

The views of this colossus may have a lasting effect on future medical practice

• When it comes to influencing medical legislation, the most powerful organization in the arena today is not the AMA. Instead, it is almost unquestionably the American Legion. For the Legion has one of the country's best batting averages in getting its resolutions enacted into laws.

This giant among veterans' organizations concentrates on getting benefits for veterans—including medical benefits. In the words of Dr. Irving Brick, its associate medical consultant: "We're not making any bones about it. We're out to see that the veteran gets a square deal."

Bill Mauldin, himself a distinguished veteran, once put it more bluntly. "The American Legion believes," wrote Mauldin in the Atlantic Monthly, "that the veteran should look out for his own interests and to hell with the next guy."

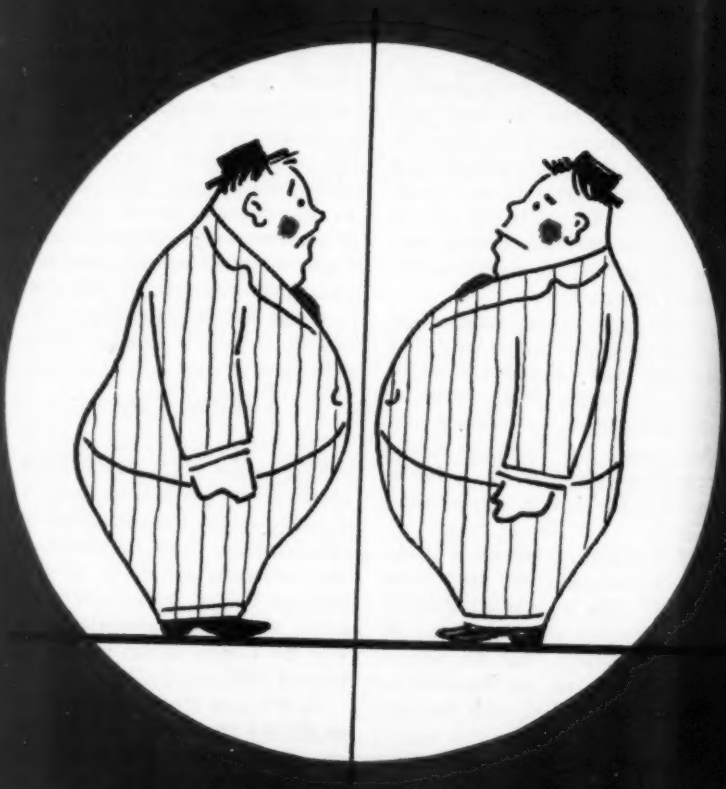
Actually, this is an overstatement of the Legion's philosophy. The Legion has opposed extending V.A. medical and hospital benefits to veterans' families and, in general, favors reduced Government spending (except, of course, for veterans). In fact, during the past few years the Legion has contributed $25,000 to the National Association for Mental Health and $50,000 to the American Heart Association. This, in spite of the fact that both mental disease and heart disease are less common among veterans than among the general population. These contributions cloud the organization's announced policy of "veterans first" and must be credited to a broader concern about public welfare.

3 Million Voters

The Legion speaks for some 3 million former G.I.'s (including about 15,000 physicians), and it probably echoes the sentiments of millions more. Since Congressmen are notoriously sensitive to the slightest furrow on a veteran's brow, it's at least understandable why the Legion carries weight on Capitol Hill.

How it uses this weight is of no small importance to doctors; for one out of every five adult patients today is a veteran. Any laws that affect the medical care of vet-

Double THE POWER TO RES



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erans are bound to have perceptible impact on private practice.

Medical care has long been a major concern of the American Legion. Its National Rehabilitation Committee employs three full-time physicians. Behind these salaried planners is a National Medical Advisory Board that recommends broad policy to the Legion's high command. This board includes such top-drawer medical names as George Lull, Leonard Rowntree, William Stroud, Franklin Murphy, Winfred Overholser, and Charles Mayo.

Where does the Legion stand on leading medical issues? It opposes compulsory health insurance and the Hoover Commission's proposed United Medical Administration. It favors more beds in V.A. hospitals, Federal aid to medical schools, and the re-establishment of the Emergency Maternity and Infant Care program. It supports the V.A. home-town plans for out-patient care.

The Legion agrees in theory that the Federal Government should not furnish free care to a veteran who has no service-connected disorder and who can afford private hospitalization. But the Legion points out that it's hard to tell in advance who can afford to pay hospital bills. After all, the length of treatment is often unpredictable. And a prolonged hospital stay at private rates might bankrupt anyone. Thus, it says, the question of "ability to pay" can't always be answered. Where there's any doubt, the Legion prefers that the Government furnish such care in a V.A. hospital.

Maternal Instinct

The Legion's attitude toward the V.A. is what the psychiatrist would call "ambivalent." One official publication comments that "the American Legion is now, has been, and will continue to be, the severest critic of the V.A." In their day-to-day work, Legion service officers often bear this out. They frequently scold the V.A. for denying service connection or for failing to find hospital beds for veterans.

But let an outside agency attack the V.A. and the Legion rushes to its defense like a hen running to protect her brood. At such times, the Legion characterizes V.A. care as "the best medicine there is in the Government." This is no tongue-in-cheek defense, either: The Legion has consistently opposed plans for putting non-service-connected veterans in private hospitals, even at Government expense.

When it comes to estimating how many hospital beds the V.A. needs, the Legion carries the torch so fast it sometimes gets ahead of the V.A. itself.

Last fall the Rusk Committee on Veterans' Medical Services reported that "a total of about 131,000 beds is completely adequate to care for all foreseeable service-connected disabilities in the present veterans' population." The Legion thinks this

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figure is shamefully low. It uses the following line of reasoning to support its case:

Since there are 19 million veterans, 131,000 beds would provide a ratio of 6.9 beds per thousand veterans. Yet for the population as a whole, there are *ten* hospital beds per thousand people. Thus, by comparison, the veteran wouldn't be getting a square deal.

Many doctors incline toward the view that V.A. beds are primarily for the 2 million veterans with service-connected disabilities; if so used, the 131,000-bed total would represent a respectable ratio of sixty-five beds per thousand. But the Legion dismisses this argument. It claims that a large part of "so-called non-service-connected" cases are—or, morally speaking, should be—service-connected.

At the end of 1948, the V.A. blueprint called for a total of 147,000 beds. In January 1949, President Truman cut this back to 131,000. The "loss" of these 16,000 beds aroused the Legion's ire. Even before the Korean adventure, it points out, most V.A. hospitals had long waiting lists (nearly all non-service-connected cases, however); so with the added burden of Korean casualties, the number of beds should be increased, not lowered. The Legion is currently backing a bill that would restore the cutback.

How many of the V.A.'s 114,000 beds do men with non-service-connected disabilities occupy? The Com-

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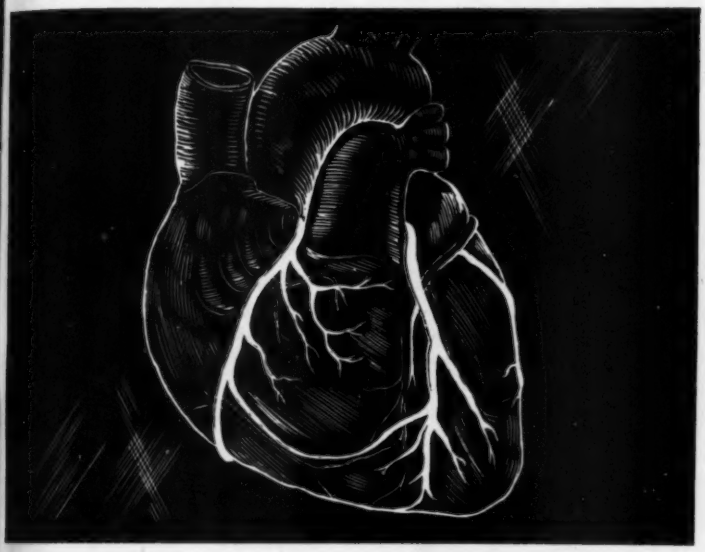

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mittee on Veterans' Medical Services found that about two-thirds of the patients in V.A. hospitals were being treated for non-service-connected disorders.

The Legion agrees that this finding is technically correct. But it insists that most non-service-connected cases have at least a moral right to occupy a V.A. bed.

Here's a revealing exercise in Legion logic:

¶ Sixteen per cent of all V.A. hospital patients have a service-connected disability but are hospitalized for something else. They ought to be counted in the service-connected group.

¶ Another 8 per cent have filed no claim. We have no right to assume that they would *not* turn out to be service-connected cases.

¶ Another 3 per cent have claims pending or on appeal. Theoretically, every one of them *could* be adjudged a service-connected case.

¶ Another 5 per cent have had their claims denied. This may have been due to red tape, technicalities in the law, or poor adjudication. Why blame the veteran for that?

¶ Another 20 per cent are receiving pensions for admittedly non-service-connected disabilities. To get such pensions, they must be practically indigent. They would have to be hospitalized at the expense of government at some level —Federal, state, or city. Hence, they are legitimate V.A. charges.

¶ Another 8 per cent have claims for such pensions still on file. They are potentially in the same group.

Grand total: 60 per cent. Subtract this from the 67 per cent who are non-service-connected. That leaves a mere 7 per cent of all V.A. patients who *may* not belong in V.A. hospitals. Which makes the Legion wonder what all the fuss is about. Adds one Legion functionary: "The non-service-connected veteran at your doorstep today may be the service-connected one tomorrow."

Private hospital interests are frankly worried about free Federal hospitalization being extended to so large a slice of the population. But the Legion seeks to calm these fears by pointing out that competition between V.A. and private hospitals is negligible. Tuberculosis and mental cases occupy about half of all V.A. beds; private hospitals wouldn't want them anyway, the Legion holds. Nor would they want those veterans who stay in the hos-

pital more than thirty days, since such patients probably couldn't pay their bills.

That leaves patients in the "general medical category" who stay less than thirty days. They are the only loss to private hospitals, the Legion contends. And the non-service-connected cases in this group account for less than 10 per cent of total V.A. patient-days.

The Legion's interest in opening V.A. hospitals to all honorably-discharged veterans is a long-standing one. The policy was first enunciated in 1919 at the Legion's first convention. The program included a plea to Congress "to provide hospital facilities for all persons discharged from service . . . irrespective of the service origin or aggravation of the disability." Similar resolutions have been passed several times since then.

On other issues (*e.g.*, bonuses and Federal housing) the Legion has changed its ground now and then. But on hospitalization of non-service-connected cases, it has remained steadfast through the thirty-two years of its existence.

Legion's Solution

The V.A. itself is not sure how many beds it wants. It has plenty of headaches in staffing the hospitals it now operates. To overcome this difficulty, the Legion suggests (1) that new V.A. hospitals be placed where they *can* be staffed; (2) that wider use be made of local private practitioners; (3) that current uncertainty about the future of V.A. hospitalization be removed; and (4) that medical school enrollment be increased.

The Legion means business about stepping up the supply of doctors. It showed this two months ago by throwing its weight behind the bill for Federal aid to medical education. Private sources of funds, in the opinion of T. O. Kraabel, head of the Legion's National Rehabilitation Commission, seem "pretty well dried up."

Government Control?

How about the threat of Government control that generally accompanies Federal aid? Dr. H. D. Shapiro, senior medical consultant to the Legion, has analyzed pending legislation with this in mind. In his opinion, it offers adequate safeguards against such control.

The Legion is also backing a bill that would set up an agency to coordinate Federal hospital activities. But control would stay with the administering agencies. Under the United Medical Administration recommended by the Hoover Commission, on the other hand, all Federal health units would actually be consolidated. The Legion is fighting this proposal, since it doesn't want V.A. facilities mixed with others.

Do the Legion's medical views reflect the opinions of its members? A high-placed Legionnaire once silenced a rank-and-filer by saying: "It's *none of your business* whether

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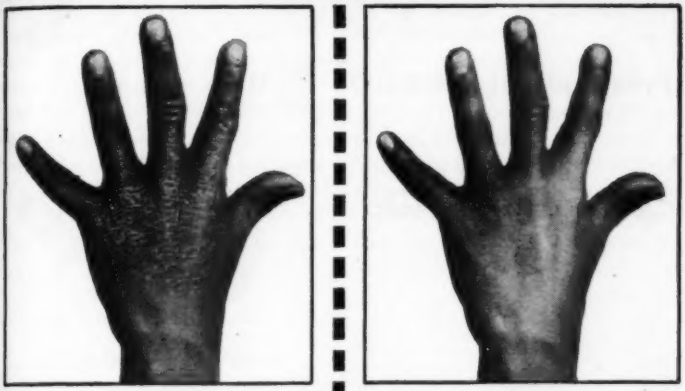

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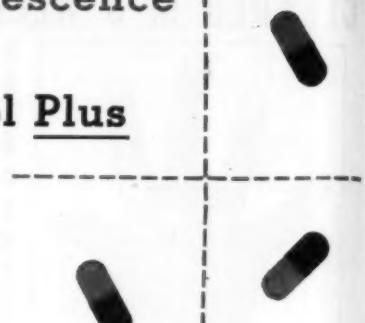

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you agree with the legislation we are pushing." Meanwhile, Time magazine has reported a revolt in the Easton (Pa.) post against the national convention's stand on the Hoover Comission report. It hints that the top brass was cramming opinion down the throats of members without giving them a chance to sound off.

Similar charges are leveled, of course, against most large organizations. These criticisms may be no more true of the Legion than they are, for example, of the AMA.

AMA-Legion Relations

Relations between the Legion and the AMA are fairly good—at least on the surface. The AMA has from time to time objected to continued expansion of the V.A. hospital empire. But it has taken no stand on the controversial 16,000 extra beds the Legion is plumping for. The two organizations seem to disagree on only two issues at the moment: the proposed revival of an EMIC program (which the Legion has endorsed) and Federal aid to medical schools.

In general, reports Legionnaire T. O. Kraabel, "our attitude has always been one of cordial cooperation with the AMA." Thus, both the Legion and the AMA have rejected a proposal that the Government furnish every veteran with a health insurance policy. The Legion objected to the plan because it would send veterans to "civilian" hospitals, where they would "lose their identity as veterans." The AMA's reasoning (also supported by the Legion): It wanted to keep the Government out of the health insurance business.

On the major medical issue of the day, both organizations see eye to eye. The Legion is opposed to "any form of compulsory health insurance." In this sphere, at least, organized medicine would agree that the Legion is indeed on the side of the angels.

—CHARLES MILLER, M.D.

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Tax Savings on GIFTS

• How much will you be worth when you die? If you look forward to a sum on the sunny side of $60,000, gifts can play an important part in your estate program.

The point is that the Federal estate tax hacks away at everything above $60,000. So the way to avert the tax axe is often to chop your estate down with gifts during your lifetime.

Gifts reduce taxes three ways:

1. They let you make some tax-free transfers of property in addition to the $60,000 exemption on your estate.

2. The gift tax is lower than the estate tax; so the same property is taxed less when turned over in a gift package than in your will.

3. A gift can even slim down your income tax.

The gift-tax law has two gimmicks that help you shuck off some of your property tax-free. One is a tax *exemption* for all gifts up to a total of $30,000 during your *lifetime*. The other is an *exclusion* that lets you give *annually*, without gift tax, as much as $3,000 apiece to any number of persons each year.

Exclusions Every Year

The gimmicks work together like this:

The annual exclusions let you make your children happy with, say,

$3,000 for Mary
$2,500 for Henry
$3,000 for Joe
Total: $8,500 in gifts
Nil in taxes

And, if you have the money, the law allows you to repeat such tax-free gifts every year. [*Turn page*]

**Rene A. Wormser, whose article is the second of a series, combines a busy law practice with teaching, writing, and lecturing to civic and professional groups. He is moderator of the estate-planning course at New York University and author of such books as "Your Will and What Not to Do About It," "Personal Estate Planning in a Changing World," "Theory and Practice of Estate Planning," "The Law," etc. He is senior partner of Myles, Wormser and Koch, New York.*

But suppose one year you want to give Joe $3,750—$750 of which is taxable. Then remember your $30,000 exemption. That can cover Joe's extra $750, leaving you an exemption of $29,250 for later years.

Now comes the gift-tax law's nicest blessing: One-half of any gift to your wife is tax-free. Suppose, for example, you planned to give her property worth $58,000. How would the tax pare it down? One-half, or $29,000, would be tax-free under the marital allowance. The other $29,000 would be more than covered by your $30,000 lifetime exemption and by your $3,000 annual exclusion. So, no tax at all.

The gift-tax law is kind in other ways too. If your wife agrees, you can use *her* exemptions and exclusions also. Suppose, for instance, you want to go all out financially for your widowed daughter Mary? Here's what you can give her, tax-free:

2 exemptions of $30,000 each	$60,000
2 annual exclusions of $3,000 each	6,000
Total gift	$66,000
Tax thereon	Nil

Juggling these breaks in the tax law will let you unload as much as $114,000 on your wife and three children in one year if you are able, and inclined, to play Santa Claus on that scale.

Now watch how a gift can reward the giver with a cut in income taxes. You're still worrying about poor, widowed Mary. You want to give her $3,000 a year. The tax-saving way to do this is to make a gift (direct to her or by irrevocable trust) of enough principal to produce that $3,000. She will pay income tax on it at a lower rate than would prevail in your high bracket. And your own income will be taxed at a rate $3,000 further down the scale.

While a gift can take any form—cash, real estate, irrevocable trust, stock, a new car, etc.—you must be able to prove it was bona fide. That gets you into semantics. For what *is* a gift?

Sometimes you skid into legal "giving" unintentionally. Thus, if you cancel a debt, that's a gift.

Conversely, what you regard as a gift may not impress the T-men as such. If, for example, you endorse some stock over to your son, then keep it yourself, it's no gift and you will be pointedly told so.

In the eyes of the law, a trust that can be revoked or amended is no gift either. An irrevocable trust is. But suppose an irrevocable trust pays a life income to you and leaves the principal to Joe at your death. Is that a gift? Only part of it is. That's why you need an expert at your elbow to advise on all gifts except the simplest.

Don't Give and Drop Dead

Your biggest tax hazard is to die within three years of bestowing a gift. For the tax men will then

assume you made it "in contemplation of death," to dodge death taxes; and unless your executor can prove otherwise, they'll tax it anyway. Only gifts made more than three years before your death are safe.

Note how tricky that term "contemplation" is:

A man of 70 who knows he's dying of cancer, gives one-third of his wealth to his son. "Contemplation of death!" says the law, and slaps on the gift tax.

Another man, 80 years old and in sound health, dips into his estate of $500,000 and gives $50,000 to his grandson to start a business. No "contemplation"; no tax.

A man of 40, with high blood pressure that worries him, gives a quarter of his wealth to his daughter for no expressed reason. "Contemplation"? Maybe. Someone's going to have to talk fast to prove otherwise.

Age, then, isn't the only test. The basic test is motive—whether the giver's real purpose was to evade death taxes.

But couldn't a tax examiner maintain that almost any gift had been made "in contemplation of death"? Good question. But there's an answer: A tax saving that's merely incidental to a gift is not proof of "contemplation."

So watch for opportunities to give your family presents in times of need. Then make a record explaining the purpose of the gift. You can even write a letter to accompany the gift ("Dear Mary: This check is to help with the hospital expenses"). Such a record may well rescue your gift from the "contemplation" class.

Of course, your best protection is to live more than three years after making the gift. And that, Doctor, is up to you, not your lawyer. —RENE A. WORMSER

Double Take

• The incident occurred in the hospital's out-patient department where, as an interne, I served in several of the specialty clinics. One morning in the medical clinic I attended a neurotic, middle-aged female whose only real complaint was a ringing in the ears. I assured her there was no organic trouble; but to allay her fears, I referred her to the otology clinic. There, I told her, she'd have the attention of one of our ear specialists, much better trained in the field than I. Imagine my confusion when, that afternoon in otology, the specialist who received her turned out to be me. —PETER FISHER, M.D.

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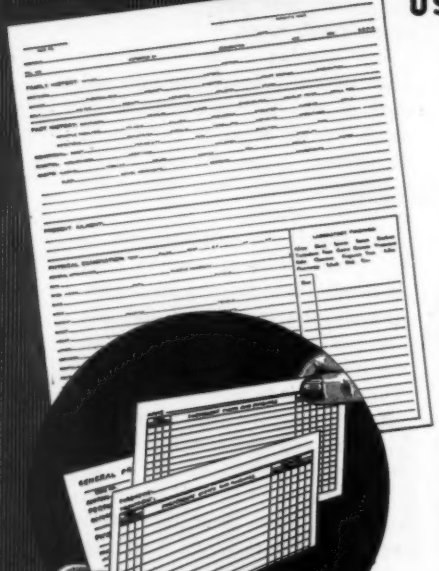

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What Doctors Think About

Non-Participation

• Ask the average private physician whether he'd take part in compulsory health insurance if it ever became law, and his answer is quite likely to be a ringing "No!"

But would he stick by his decision when the fateful day came? Could he resist the economic and political pressure to sign up? Would he get effective support from his medical colleagues?

These piercing questions stem from an article this magazine published in January. It described how a coordinated program of non-participation might be put into effect, as envisioned by the Association of American Physicians and Surgeons. Highlights of the AAPS proposals:

¶ "The plan calls for doctors to stay aloof from any [Government-controlled] scheme; to provide all needed medical service; but to treat all comers as private patients, not as beneficiaries of the Government system."

¶ "We believe [AAPS leaders] could enroll 90 per cent of the nation's eligible physicians within forty-eight hours if threatened by passage of a socialized medicine law . . . We hold that the number of backsliders would be negligible."

¶ "Most patients would continue to pay their doctors just as they do now. We do not believe this would constitute a problem."

¶ "There are *no* steps the Government could take to upset the non-participation program . . . We believe it would break the back of any political medicine scheme."

The Doctors Disagree

There you have the views of one segment of the medical profession. What do other doctors think?

Take a look at the provocative comment that follows. It comes from AMA officers, delegates, and trustees; from leaders in state, county, and specialty societies; from medical public-relations men; and from rank-and-file private practitioners. Their views are presented not as a scientific opinion sampling, but as an indication of how sharply doctors disagree over the non-participation idea.

From Dr. George S. Klump of

Sodium Gentisate: A New Approach to the Treatment of Arthriti

It has been estimated[1] that nearly 7,000,000 people in the United States have some form of "rheumatic" disease. Rheumatism (with arthritis the most important single cause) ranks first in prevalence among diseases, and second in the production of disability and invalidism. It is more common than the total number of cases of tuberculosis, diabetes, cancer and heart disease combined.

The most common of the severe forms of the arthritides is rheumatoid arthritis. Since Klinge's[2] original work in 1929, evidence has been accumulating that both rheumatic fever and rheumatoid arthritis are diseases of the interfibrillar substance of the connective tissue[3]. The nature of this material is not well understood, although it is presumably a mucopolysaccharide in combination with a protein. This theory holds that changes in the cellular components are secondary to changes in the interfibrillar material. The composition of two of the mucopolysaccharides found in interfibrillar material is known: (a) chondroitin sulfuric acid and (b) hyaluronic acid[4].

Changes in the hyaluronic acid of the joint fluid have been shown to be present in active rheumatoid arthritis[5,6]. These changes in active disease involve a depolymerization of the hyaluronic acid. The excessive presence of hyaluronidase, moreover, has been acknowledged to produce a denaturization of mucin in the synovial fluid, the varying degrees of which are valuable for their diagnostic as well as prognostic indications[7]. Clinicians[8] have concluded that the increase of hyaluronidase activity may be responsible for the breakdown of interfibrillar cement.

A rational approach to the problem, therefore, demands a therapeutic agent that will act to inhibit the spreading effect of hyaluronidase. Gentarth Tablets provide just such an agent, sodium gentisate.

Meyer and Ragan[9] treated patients having rheumatoid arthritis and acute rheumatic fever with sodium gentisate. Their results were uniform and notably favorable. Within a few days there followed a disappearance of pain, swelling and joint inflammation.

The favorable therapeutic effects of sodium gentisate have been confirmed by other investigators,[10,11] Gorsuch[12] reporting that the "therapeutic efficacy of sodium gentisate has exceeded that of salicylates and its antirheumatic properties apparently exceed those of an analgetic and antipyretic action".

The increase in urinary glucuronic acid observed with salicylates does not occur with gentisates. This phenomenon has been assigned to the rapid oxidation of the gentisates[13]. It is indeed likely that the antirheumatic action of the salicylate in forestalling the spread of hyaluronidase[14] is attributable to its partial oxidation in the body to a gentisate.

SODIUM GENTISATE

The corrective action of sodium gentisate is generally not an immediate one; therefore, as an added therapeutic measure, a salicylate, which provides prompt relief from pain, should be included in the formula.

Boyd *et al.*[15] treated 80 patients suffering from different arthritic diseases with sodium gentisate combined with salicylates and also with salicylates alone; they found the gentisate-salicylate composition (GENTARTH) to be the more effective, with best results following its use in patients suffering from rheumatoid arthritis and fibromyositis. The relief afforded by the sodium gentisate component in these diseases appears to be unmistakable. These investigators also found GENTARTH to be remarkably free from toxic effects, no untoward symptoms having developed in any patient. This finding confirms the observations of Mulinos[16] that GENTARTH has a very low order of toxicity, both chronic and acute, in animals.

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GENTARTH Tablets are supplied in bottles of 100, 500 and 1,000 and are available at all pharmacies on prescription.

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Send request for sample and literature on your prescription form to Raymer Pharmacal Company, Philadelphia 34, Pa.

Williamsport, Pa.: Any physician with the degree of social consciousness expected of an educated adult will reject non-participation immediately without bothering to analyze his reasons. If he has been studying the problems related to the distribution of medical care, he will recognize that a non-participation threat is the ultimate negative approach to a task that has almost infinite positive opportunities.

• • •

From Dr. Hugh Smith of Greenville, S. C.: The AAPS plan is practical if a major percentage of the medical profession agrees to support it. Provided that a good selling job is done, with every emphasis on the fact that we would continue to serve the public, I think it would achieve its purpose.

If a health insurance law were ever enacted, however, it's doubtful that any organization could work effectively against it. The only sound program, therefore, is to publicize non-participation *beforehand*–so that Congress will think twice before passing such a law.

• • •

From Dr. E. Vincent Askey of Los Angeles: The AAPS article presents the unstudied reaction of

"Oh, no, just specimen bottles."

practically every doctor who is confronted with the direct question as to whether he would cooperate with compulsory insurance plans. He answers at once, "I certainly would *not!*" But when he thinks about it some more, he realizes that he'd probably be *forced* to cooperate.

I wish non-participation *were* practical, because my sympathies are with those who propose such a plan. I agree that pledges could be obtained from many, if not most, doctors to the effect that they would not participate. But I disagree with the suggestion that these pledges could easily be kept.

The AAPS article says, "The Government may pass the law and tax the people, but it cannot force physicians to give up their private practices and become Government employes." This reminds me of the old Army saying: "The Sergeant can't *make* you do anything—but he can damn well make you wish you *had* done it!"

It is high time we quit fooling ourselves. If compulsory health insurance is ever enacted, we will have two strikes on us—and no balls! We must stop planning what we will or won't do *after* the law is on the books. All our efforts must be directed toward defeating such proposals. We can keep private practice if we fight for it intelligently.

• • •

From Dr. L. Howard Schriver of Cincinnati: The non-participation plan is practical in theory. The destiny of the medical profession *can* be determined by the medical profession. However, this statement assumes solid, cooperative resistance by the *entire* profession. Any appreciable break in its ranks would make the plan fail.

A fairly large percentage of the profession could meet their obligations over an indefinite period without earned income—if that proved necessary. But most of our younger colleagues could not. I feel it would be essential to contribute financial

Mouths of Babes

• The incident happened years ago, when my shingle was shiny new, and was recently told me by one of my oldest patients. One day he found himself no longer the sole occupant of my waiting room; someone else had decided to give the new doctor a try. As they awaited my return from a call, my young son bounced into the room. For a moment he stood transfixed, plainly incredulous and delighted. Then: "Oh, boy, *two!*" he burst out. "'Will Daddy be surprised!" —M.D., NEW YORK

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assistance to these younger and less fortunate doctors. This I would be willing to do.

I will never practice my profession in cooperation with any system which is Governmentally directed or controlled. I do not believe any part of the non-participation plan to be unrealistic, as long as we live in a Republic and under the Constitution of the United States.

• • •

From a Virginia medical leader: I don't think the non-participation plan should be adopted by our profession. If the majority of Americans, through their representatives in Congress, vote overwhelmingly for compulsory health insurance, I believe we doctors should try to make it work.

• • •

From a physician in San Francisco: Non-participation *is* practical—provided that our leaders are men of character, determination, and energy. I believe that about fifteen such men throughout the country could persuade the majority to sign a manifesto of non-cooperation.

I'd suggest only two refinements in the AAPS plan: (1) the appointment of associates to each of the fifteen key "Minute Men"; and (2) the provision of funds for their rapid transportation around the country when mass enrollment became necessary.

• • •

From Dr. Frank L. Feierabend, Kansas City, Mo.: I consider the proposed non-participation plan to be beneath the dignity of the medical profession. It seems to me the plan is actually a sort of sit-down strike. No strike ever accomplished anything worth-while.

• • •

From Dr. Alfred S. Hartwell of

Honolulu: If carried out by the vast majority of U. S. physicians, non-participation would succeed. There are five groups of doctors, however, who would be disinclined to support the idea:

1. Those already in Government service. These men would have little to gain by putting up a fight against socialized medicine.

2. Physicians who actually favor Government-controlled medicine, such as Channing Frothingham's group. Such men obviously would not sign a non-participation pledge.

3. Medical men who might be unwilling to fight the system. The AAPS article mentions the case of the city-operated Health Service System in San Francisco, where *most* doctors declined to participate. But the point is, *some* doctors stuck with HSS. A comparable group would go along with any national health scheme.

4. Physicians who would never refuse to treat patients, no matter what the method of payment. These men could not live up to a non-participation pledge.

5. Physicians who'd feel that the law of the land must be obeyed. The majority has spoken, they would say; there is nothing to do but comply.

I am afraid that these five groups would claim a fairly large proportion of the doctors in this country. Universal non-participation would thus be impossible to hope for.

• • •

From a medical society public relations director: The non-participation plan is a desperate, last-ditch defense. It should not be considered as long as medicine has a chance to win its fight on the merits of the issue involved.

Even though I agree that doctors have the inalienable right to refuse to practice medicine under any system which is abhorrent to them, and even though I recognize that this would *not* be a strike against their patients, our critics would so interpret it. They would do their utmost to inflame public opinion against the medical profession, if we were ever forced into a non-participation defense.

We are not in such desperate straits that we need such a defense. Why ask for trouble by suggesting it?

• • •

From Dr. George A. Woodhouse, Pleasant Hill, Ohio: I have seen the formation, decline, and fall of several medical organizations that have turned out to be pressure groups against the AMA. In my opinion, the AAPS is one of those pressure groups, with an inadequate membership to further any of its proposals. The association should fold up and vanish from the medical scene.

Holding the threat of a "medical union" over Congress will get us nowhere. It will simply give the socializers more ammunition than they have ever had before.

• • •

From a West Virginia medical

leader: In my opinion, the AAPS plan is both legal and practical. I wouldn't change a single detail of the plan. Employed just as described in your article, non-participation should succeed.

• • •

From a doctor in Colorado: I don't think non-participation would really work. Why? Because many doctors who took the pledge in good faith would be forced by financial circumstances to break that pledge if political medicine became a reality.

Most physicians could not switch to another occupation. Hence they'd be reluctant to abandon their only sure source of income, no matter how repugnant the method of payment.

In addition, I question the political value of a non-participation threat. Oscar Ewing has given no sign that he considers it a danger. I don't think it would change one vote in Congress, except possibly by antagonizing some of our friends. And if the idea were pushed hard, public reaction might also be unfavorable. It would be too easy for our enemies to make it look like a "strike against the sick public."

• • •

From a western medical society officer: I thoroughly believe in the AAPS objectives. But if any non-participation program is to succeed, it *must* be run by the AMA. With all due respect to the AAPS, I feel it is too spottily organized, too much opposed in many places, to count on maximum professional support.

• • •

From Dr. Hilton S. Read of Atlantic City: Would non-participation really work? It definitely would not!

The statement that "most patients would continue to pay their doctors just as they do now" is unadulterated wishful thinking. The payment of a physician's bill has never been popular; it would be even less popular if there was a chance to have the Government pay it.

Gradually, a workable system is being evolved for the qualitative medical care of *all* our people. But perfecting the system is going to take the full cooperation of doc-

"Soft job these doctors have. You tell them you're tired and they tell you to go get some sleep."

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tors, Government, white-collar groups, labor, management, farm organizations, and such. We must sit down around the conference table in an atmosphere of trust and honesty. Non-participation and all other strong-arm techniques must be checked in the anteroom.

• • •

From Dr. Robertson Ward of San Francisco: There is a very good chance that non-participation would work. American physicians have demonstrated from time to time that they *can* act together in their common interest if sufficiently aroused by an outside threat. But it is essential to wait and see what actually happens before planning the tactics of battle. Military history is full of beaten armies that planned their weapons well in advance, only to have the enemy refuse to cooperate.

AAPS officers must well know that the socializers are trying to get control of medical practice by the back door. If they have their way, a time will *never* come when the medical profession can say, "So far we will go and no farther." Where does that leave the non-participation plan?

• • •

From a doctor in Washington, D. C.: The non-participation plan, as described in your pages, evades a critical question: Would people be willing to pay twice for medical care?

Any compulsory plan is going to cost the average citizen plenty. What's more, he'll pay from the day it's enacted—either in general taxes or through earmarked payroll deductions.

Suppose that after paying about $200 in such taxes, a patient with an enlarged prostate goes to his family doctor. Suppose he needs a prostatic examination, a urologic X-ray, and finally a prostatectomy. Suppose he's told that all this will cost him $288 extra—$3 for the family doctor, $10 for the urologist, $25 for the radiologist, $250 for the surgeon.

Will he pay those extra fees? Not if he's an average wage-earner. He can't afford to.

Then what? Does the family doctor say, "If you don't pay, you can continue to bleed whenever you urinate—and keep on bleeding, for all I care"? Is that what non-participation means?

Or does the urologist say, "No money, no examination; keep on getting up six times a night—you can't regiment me"?

Of course not. Rather than see his patients remain in pain, the ethical M. D. will treat them for free. And, to keep from starving, he'll eventually have to accept the Government checks.

• • •

From a Philadelphia physician: I am completely sympathetic to the spirit evidenced by those advocating the non-participation program. I, for one, will not take part in any political scheme such as compulsory sickness insurance. But even though

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the time may come when preservation may dictate such measures, I am inclined to think the AAPS program somewhat premature.

We have made great strides in the last few years in winning public support. It seems to me this support might be seriously endangered if doctors were to act as guild members instead of as professional men.

* * *

From a top officer of the AMA: It has been my feeling for years that the AMA should do the whole job for American medicine. Organizations like AAPS and the NPC tend to divide us to some degree. On the other hand, I want AAPS to persist as an organization—so that if we ever need the non-participation program as a last resort, it will be there.

Attorneys for some of our state medical associations tell us that any official endorsement of the AAPS program might bring us into conflict with a state law against monopolies in restraint of trade. These lawyers feel that organizing a boycott against socialized medicine *before* it is enacted might well be construed as conspiracy. AAPS attorneys dissent violently from this point of view, and I don't know who's correct. But safety lies on the side of not giving AAPS official recognition—at least not in my home state.

I feel that open espousal of non-participation at this time would be a bad stroke of public relations. Even in the long run, I doubt that the plan would succeed. But if socialized medicine is ever forced upon us, many doctors will unquestionably be willing to give non-participation a try. I probably will myself. **END**

Oh, my aching feet!

For fast relief of muscular aches and pains

SUGGEST

Absorbine Jr.

U.S. Primes Public Health Pump

Will Federal aid put new pep into programs for local public health services?

• Thousands of doctors who double as part-time health officers are watching Washington these days. They're likely to lose their jobs, and their attitude depends on whether they're glad to get rid of health-officer chores or sorry to lose the sideline income.

For Congress has hewed out two public health measures (H.R. 274 and S. 445) which may soon spread a network of county-size health units throughout the country. And physicians whose practices will be caught in the net are asking a couple of questions:

1. Is Federal aid to local public health units a sneak approach to Federal control?

2. Are new public health units going to relieve or multiply the private physician's headaches?

By starting with the pending bills you can get a line on the answers. Both Senate and House versions of the legislation stress these key words:

¶ "Full-time public health services . . . " Only full-time units will receive Federal help with their payrolls, which suggests that the part-time health officer may be headed for the last round-up.

¶ "Essential to the security and well-being of our country . . ." Local public health people will have the job of hanging out danger signals if atomic attack makes a locality's food and water Geiger-hot. They'll also have the job of protecting millions of civilians in case of bacteriological warfare.

¶ "In all areas of the nation . . ." Almost every state has some backward districts to blush about. The new program is designed for such trouble spots.

¶ "Population to be served . . ." The minimum per local health department will be between 20,000 and 35,000 people. Neighbor counties or townships are encouraged to club together for a health unit of maximum size.

¶ "Training of all types of personnel for local public health unit work . . . " Severe shortages of qualified workers may be eased by special training.

Bipartisan Support

The health services for which Federal aid will be given include diagnosis and prevention of disease,

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control of communicable disease, health education and demonstrations, sanitation, vital statistics, and other aspects of preventive medicine.

Washington-wary physicians are not only eyeing the legislation; they're watching the company it keeps. The plan has had bipartisan approval from the start. A Democrat and a Republican raced to introduce it in the House. In the Senate, eight Democrats and seven Republicans sponsored the measure jointly. Senator Robert A. Taft (R., Ohio) gave it this send-off:

"The bill is of great importance . . . [It] is independent of compulsory health insurance and has nothing to do with it. In fact, [I] think that it will remove some of the arguments which have been advanced in favor of that particular program."

Hostility to the Federal aid idea has not slowed down the legislation. Both Senate and House versions are carefully written to avoid accusations of Federal pressure. States are free to formulate their own public health plans and, after approval by the Surgeon General, to administer both their own plans and their share of the Federal funds. The House version orders states to give public health priority to "national defense areas." Otherwise, they're on their own.

To insure against Federal meddling, the Surgeon General's hands are tied with several strings. He is specifically prohibited from pressuring about personnel, jobs, or pay. He's required to approve state plans that "substantially comply" with the legislation. If a state feels like kicking about his rulings, it is assured a court hearing.

The Surgeon General can, however, prescribe "general methods of administration." If any state fails to follow them, he is authorized to shut off the shekels.

Under the new program, a typical state might collect for one-third of its minimum public health expense. But a greater share will be paid to poorer states in the degree that their per capita income drops below that of the U.S. One health expert figures that if all states participate, the program can cost the U.S. about $75 million a year; the current U.S. budget allots only $5 million.

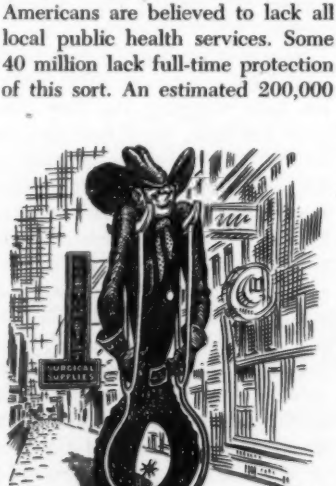
Reluctant to drag its feet on a semi-defense measure, the AMA has been weighing the new program carefully. Some time ago, at the AMA's request, the sponsors of the legislation revamped it to trim the Surgeon General's powers. But the fear remained that public health personnel might still encroach on private practice. This objection was met by specifically excluding "medical, dental, or nursing care" from the legal definition of public health services (except in the control of communicable diseases). The AMA finally agreed to support the program if a few further specific changes were made.

The clamor for local public

health units started a decade ago, when war travel took many city dwellers to the more backward areas of the U.S. Physicians were among those startled to discover how many regions indulged in no milk inspection, drank water of questionable origin, handed around communicable diseases with chummy generosity, and wasted no money on health officers who might shake a disapproving finger.

In June 1942, the AMA passed a resolution urging "complete coverage of the nation's area and population by local, full-time modern health services." Bills for Federal aid to bolster local health departments have been inching through Congress practically ever since.

As of today, some 9 million Americans are believed to lack all local public health services. Some 40 million lack full-time protection of this sort. An estimated 200,000 people a year die of diseases that public health units are designed to clean up.



A longtime campaigner for the new program has been the National Advisory Committee on Local Health Units of the National Health Council. Its dynamo is Dr. Haven Emerson, emeritus professor of public health at Columbia University. "No one state or locality," he says, "can be entirely safe from preventable diseases until all states are covered by modern, full-time local health departments."

His bulky monograph, "Local Health Units for the Nation," has been an unofficial blueprint for the current program. It holds the best hints yet available of what doctors may expect from local units:

1. Fewer rather than more local public health units may soon be the order of the day. Many existing units are too small to pay for the services of good men.

2. Medically-trained health officers will be sought. Higher salaries offered by consolidated units, plus Federal aid, may bring in a number of P.H. career men.

3. More complete public health laboratory services will be available to help local doctors with puzzling diagnoses.

4. More public health clinics will probably seek the services of local physicians, on a fee basis.

5. Educational programs of the public health units may send more patients to the doctor for early treatment.

—H. C. MILIUS

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NURSE... *The Doctor's new technic with the HYFRECATOR is wonderful!*

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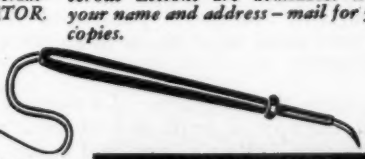

to eradicate moles, warts, unwanted hair and other superficial growths. Many doctors use the HYFRECATOR...High Frequency Eradicator...for fulguration and bi-active coagulation as well as desiccation. They find that the HYFRECATOR'S double spark gap power, accurately controlled and smoothly graded current... exactly meets their individual office electrosurgical demands.

ERADICATE THAT SUSPECT PRECANCEROUS LESION

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Please send me free reprints on Precancerous Lesions and Literature on the Hyfrecators.

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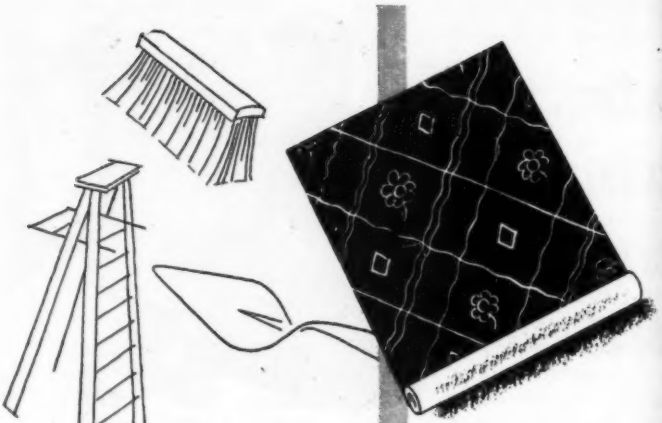


before you wallpaper

It is necessary to wash and size a plaster wall thoroughly before you hang wallpaper if you want the best possible result.

And in the treatment of many dermatologic conditions the preparation of the skin before medication is applied is equally important. The use of pure, mild **MAZON** Soap to cleanse the affected areas does much to enhance the therapeutic action of **MAZON.**

For more than a quarter of a century, physicians have used this dual therapy in acute and chronic psoriasis, eczema, alopecia, ringworm, athlete's foot, and other skin conditions not caused by or associated with systemic or metabolic disturbances. **MAZON** is greaseless . . . requires no bandaging; apply just enough to be rubbed in, leaving none on the skin.

MAZON

Antiseptic • Antipruritic • Antiparasitic

BELMONT LABORATORIES, Philadelphia, Pa.

Jottings From a Doctor's Journal

• Six months ago John Bizek, 64, sought help from the neighborhood doctor for his hypertrophied prostate and was started on a course of testosterone. His ambition, which had not extended beyond the desire to get four hours' uninterrupted sleep, soon widened to include a lively blonde of 35. They were married three months ago.

But the incidental expenses must have strained a budget not quite designed for matrimony. Mr. Bizek had to forgo the expensive androgenic treatment and soon thereafter suffered a waning of impetuous ardor. He is single again now, and is being prepared by another doctor for prostatectomy.

He is in hopes that the post-operative complications may not be quite so distressing as have been the pre-operative ones.

• • •

At a staff meeting, Dr. Jan Tussek tells of a former patient who, a month earlier, reeled out of his favorite saloon and collided with a passing street car—with negligible effects on the car, but fatal damages to himself.

"Now," says Tussek, "the patient's family are suing the saloon for the father's death. They want me to testify that the old boy would still be alive had not the cup that fuddles been made available by the saloon-keeper. The saloon-keeper wants me to swear that the poor departed had cirrhosis of the liver long before this saloon ever opened for business.

"So the family lawyer asks me home for dinner. The saloon-keeper offers me free drinks. And I just can't make up my mind."

• • •

All through Mr. Hoag's visit, I sense a measure of reserve. There seems to be nothing about a dislocated shoulder that a man need be ashamed of. Yet he is clearly uncomfortable, as if holding something back.

With his humerus restored to his glenoid fossa, Mr. Hoag is about to leave. Suddenly he plunges into confession:

"You know, Doctor, my coming to you is really a special compliment. I'm a doctor myself—a doctor of chiropractic."

I cannot find it in my heart to charge a poor man who has worked too hard at his trade and has suffered an occupational injury. After all, who knows how near the time may be when I, too, may fail from overwork and be in need of an adjustment? [*Turn page*]

for all skins sensitive to ordinary soaps

DERMOLATE, supplied in smooth-lathering cake form, is a scientifically compounded detergent with hypoallergenic properties. It is particularly suited for routine skin cleansing when even the mildest of ordinary soaps is poorly tolerated.

Dermolate is especially recommended for daily use in baby's bath.

White's

WHITE LABORATORIES, INC., PHARMACEUTICAL MANUFACTURERS, NEWARK 7, NEW JERSEY

In the staff room, Radiologist Feelon confesses to the lowest crime a specialist may sink to: the admission of limitations to his specialty.

"This maid of ours has been with us only four days. But she found out I'm an X-ray doctor. So last night she asked to speak to me 'personal.' The gist of it is that she has inflamed tubes and doesn't want an operation—can I give her X-ray treatment? Well, all of you know we radiologists take care of everything from Acne to Zoster, but how can I bring her to the office and face my wise-guy technician?

"I had to tell her I can't treat her condition. So now my wife's in the market for a new maid. Anybody here know one with a sound set of tubes?"

• • •

There *are* new things under the sun, and maybe this was one of them. The typewritten words on the fly-leaf of the man's chart read: "Climacteric mole." On the admission note, in the interne's athetoid writing, the diagnosis was "Mole climacteric."

Was this a new medical entity that had sneaked up on me? Would it now be necessary to forgo wasting nights on sleep and read more extensively?

Nothing so serious. There was no mole. The wording intended had been "Male climacteric." And there was no climacteric either. The patient's impotence was entirely psychic, and was shortly reported by him as completely cured. It had been induced by the calamitous post-nuptial discovery that the bride's financial assets were as imaginary as the lady herself was substantial.

• • •

The man who walked into the clinic was an impressive gentleman—regally bewhiskered, with an air about him of a latter-day Walt Whitman. I glanced at the name on the folder.

"Mr. Stilson?"

He frowned slightly. "*Dr.* Stilson, please." I excused my lapse.

In the course of the interview, it came out that my colleague had formerly been in the habit of refueling with a quart of whiskey each day.

"That's considerable drinking, isn't it, Dr. Stilson?"

"Not at all, sir. It was excellent whiskey."

"But didn't it interfere with your work?"

"Not in the past five years, Doctor. I've been in the penitentiary."

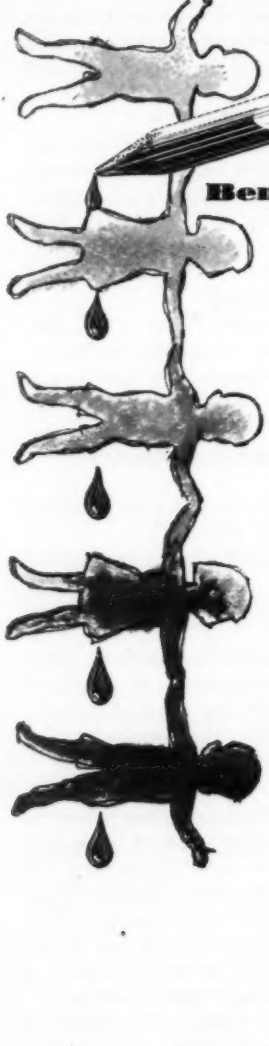
"Indeed? May I ask what for?"

"Certainly. They wouldn't let me distill spirits for medicinal use."

• • •

Dr. Ballard, compiling figures on the contraceptive effectiveness of a jelly of his own composition, has run into the usual snags that tangle statistics. His latest case in point is Mrs. Finley, whose reliance on the jelly resulted in the appearance of an unforeseen Finley offspring.

She has absolved Dr. Ballard of all blame, however, and for good



Benat Drops *keep growing youngsters healthy—strong*

Benat Drops *help infants and children to keep pace with rapid development.*

Benat Drops *are a palatable nutritional Vitamin B supplement, especially rich in Vitamin* B_{12}.

Benat Drops *are provided in a pleasant-tasting vehicle readily miscible with milk, formulae, fruit juices, cereals and other foods.*

Formula

Each 0.6 cc. or 10 minims contain:

Vitamin B_{12}*—Crystalline*	*2.5 mcg.*
Thiamine Hydrochloride	*2.0 mg.*
Riboflavin	*0.5 mg.*
Niacinamide	*30.0 mg.*
d-Pantothenyl Alcohol	*3.0 mg.*
Pyridoxine Hydrochloride	*0.5 mg.*
Alcohol	*5%*

How Supplied: *Bottles of 30 cc. (1 fluid ounce) with calibrated dropper. Benat containing* B_{12} *also available in Tablets and Injectosols.*

Benat Drops

Kurdon, S. C. and Cornell, E. L.: Vitamin B Complex in Neonatal Feeding. Am. J. Obst. & Gynec. 56:853-860, 1948.
Wetzel, N. C.; Fargo, W. C.; Smith, I. H. and Helikson, J.: Growth Failure in School Children as Associated with Vitamin B_{12} *Deficiency —Response to Oral Therapy. Science 110:651-653, 1949.*

The National Drug Company *Philadelphia 44, Pa.*

more than half a century of service to the medical profession

reason: In the dark and confusion of an urgent moment, Mrs. Finley inadvertently substituted for Dr. Ballard's product a tube of toothpaste.

It appears, in consequence, that whatever other properties this well-advertised dentifrice may have, its spermicidal action is a proven dud.

• • •

Throughout the hospital stay of Ulysses A. Homer, a steady stream of insurance company forms poured into the office. The girls were kept busy detailing the many disabilities of the insured and sending discouraging forecasts as to the date when Mr. Homer might be expected to return to work.

In due time, Ulysses was gathered to his fathers. Whereupon a pink form arrived from yet another insurance company, titled: Proof of Death. There was the usual questionnaire on diagnosis, past and present; cause of death; and autopsy findings, if any. At the very bottom of the form, in bold type, as a sort of urgent afterthought, came the question:

"Is the patient able to return to work now?"

• • •

In business competition, your product may not outshine others in the field; but there is still that intangible veneer, Service, which—deftly applied—may make all the difference. It was in the untarnished spirit of Service that the mousy little man approached a number of internes at the hospital with the startling offer of a limousine and chauffeur any evening the doctor had an extra-special date.

There were no strings tied to the fenders. It would merely be considered a courtesy—unrelated, of course, to the car—if the doctor would remember to mention the phone number of a certain high-class undertaking establishment whenever there was a death on his ward.

• • •

Intermittently, for three long years, Jim Morton made the rounds of doctors' offices, seeking guidance about the mole on his abdomen. The refrain seldom varied:

"You say it's harmless, but look where it is—right over my intestines. Suppose it grows inside and starts trouble?"

A month ago, Jim went down with acute appendicitis, was taken to the hospital, and had his appendix removed. "What did I tell you?" he gloated. "If a fellow isn't a doctor, he just don't know a thing, eh? I guess I needn't have had appendicitis if you fellows had only listened to me."

It wasn't until Jim was dressing to leave the hospital that he saw his scar for the first time. He gasped in angry astonishment: "Sa-ay! That mole is still there! What are they doing, looking for more business?"

He has finally responded to his surgeon's bill for services—with a suit for malpractice.

—MARTIN O. GANNETT, M.D.

I Invested in a Chicken Farm

Both dividends and headaches are bigger than in the stock market, this story suggests

● For a long time, I'd wanted to diversify my investments by putting some money into a farm. A few years ago, when my brother-in-law was casting about for something to do, I made him a proposition: I'd buy a farm, he'd run it, and we'd split the profits.

The idea appealed to him. Joe had a side income and, after a rough time in the war, a yen for the solitude of the country.

He leaned toward chicken farming, and that's what we settled on. In the two months it took us to find a place we liked, he studied up on the subject. It was midwinter by then. We decided to specialize in Rhode Island Reds, buy our chicks from southern hatcheries, and raise them in heated brooders. We figured we could start putting broilers on the market long before other farmers had their hen-bred chickens ready for sale in the spring.

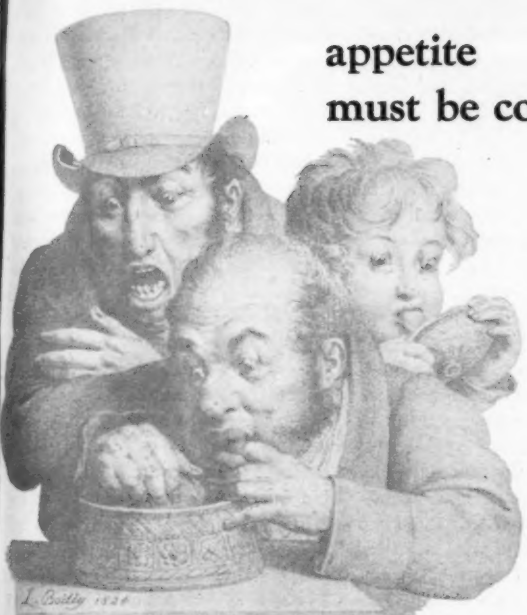
The farm we picked—a convenient forty miles from my urban office—was a ninety-acre place. It had a ten-room house, plus a wood shed, smoke house, pig sty, chicken house, granary, and barn. It listed at $11,000. I got it for $10,000, then put another $2,000 into a used truck, brooder stoves, and conversion of all outbuildings to chicken houses.

A local bank readily loaned me $5,000 on a first mortgage at 4½ per cent. My total cash investment: $7,000.

As soon as Joe and his wife moved in, the first batch of 500 chicks arrived. They cost $60 a batch. We figured we'd be selling the grown birds two months hence at $1.20 apiece, or $600 for the lot. After deduction of $100 for feed, depreciation of equipment, and other expenses, we'd net $500 on each batch. With new batches coming in every two weeks, we'd soon be sharing a $250 weekly profit—so we thought.

Our arithmetic was okay, but we

**Like a good many physicians, the author decided to wrap up some of his spare cash in a farm. His experience, which he prefers to tell anonymously, offers useful tips to any doctor with a farm in mind.*



appetite must be controlled

"The greatest problem in preventive medicine in the United States today is obesity."[1] And today it is well-known that *"The only way to counteract obesity...is by a restriction of food intake."*[2]

'Dexedrine' Sulfate controls appetite, making it easy for the patient to avoid overeating and thus to lose weight safely without the use (and risk) of such potentially dangerous drugs as thyroid. In weight reduction 'Dexedrine' *"is the drug of choice because of its effectiveness and the low incidence of undesirable side effects."*[1]

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Dexedrine* Sulfate

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The most effective drug for control of appetite in weight reduction

*T.M. Reg. U.S. Pat. Off.

1. Walker, W.J.: Obesity as a Problem in Preventive Medicine, U.S. Armed Forces M.J. 1:393, 1950.

2. John, H.J.: Dietary Invalidism, Ann. Int. Med. 32:595, 1950.

couldn't get it across to the chicks. They were too busy dropping dead. Instead of 500 grown fowl by marketing time, we found we were getting fifty or sixty.

In nine months, I lost $1,500. Joe, who'd been getting up all hours of the night to tend the temperamental brooder stoves, was fed up too. Then the state experimental poultry station, where we'd been sending dead chicks for autopsy, crashed through with the final bit of bad news:

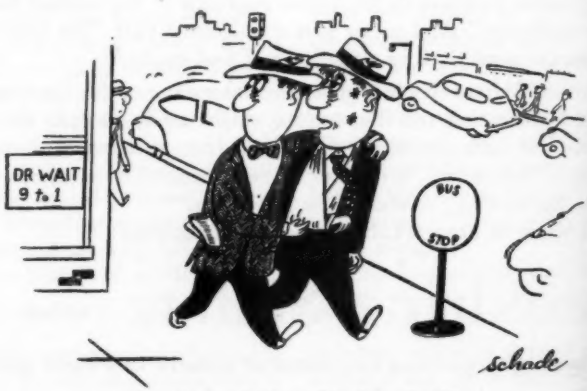
Our birds had white diarrhea. It was incurable. And the bug was so virulent that if we ever wanted to raise chickens again, we'd better burn our brooder houses and plow up the ground they'd been on.

Instead, we boarded them up and held a council of war. Our fatal error had been buying chicks of unknown parentage. We should have developed our own blood-tested parent stock, hatched our own chicks in incubators. But that would now take more money than I wanted to sink in the venture. And Joe, if he was going to have anything more to do with chickens, wanted a salary *plus* half the profits—if any.

We settled on $1,800 a year. And, because we'd had some luck producing eggs as a sideline, we decided to try them as our main crop.

By the end of the year, things were looking up. To recover my losses on the broilers, we re-opened an old gravel pit on the premises and sold sand to local building contractors. We also sold countless cords of firewood and had a neighbor cut twenty acres of our hay on a fifty-fifty basis.

The egg business was going well too, because we'd started small and learned as we went. Our initial flock was 100 White Leghorns, sep-



"I gotta get better odds than that!"

arately cooped and untouched by the disease. We added 900 more, bought additional equipment, and remodeled the barn stalls to serve as hen houses. This cost another $1,000, bringing my over-all investment to $8,000.

We still had some tricks to learn in the egg trade. For instance, we'd built our chicken runs big enough for a flock of several thousand. But our hens got lonesome, with all that space, and quit laying. When we closed part of it off, they began to produce again. And when we put a radio in the barn, they did even better.

In the first year, our 1,000 birds produced 16,000 dozen eggs. They brought an average of 42¢ cents a dozen wholesale, grossing us $6,720. Here's how our expens shaped up, in round figures:

Joe's salary	$1,80
Depreciation	1,20
Amortization of flock	30
Mortgage interest	22
Feed	70
Fuel, crating, shipping	70
Taxes	10
Other expenses	25
Total expenses	$5,27

That left us a net of $1,445, o $722.50 each. On my $8,000 investment, I realized nothing the first year (broilers), a 9 per cent return the second year (eggs).

That's a better yield than you'll readily come by nowadays in the stock market. And a stock certificate isn't half as succulent as a nice fat Leghorn. END

How hexachlorophene in

Dial Soap

can protect you and your patients!

Medical research has demonstrated the remarkable antiseptic qualities of hexachlorophene soaps. Dial was the first hexachlorophene soap to win wide public acceptance. People have been delighted to find that an antiseptic soap could be so mild, fragrant and rich-lathering. Many doctors are recommending the protective benefits of Dial Soap for patient use in both homes and hospitals.

- *Reduces skin bacteria count* as much as 95% when used regularly – reduces chance of infection following skin abrasions and scratches.
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- *Protects infants' skin*—helps prevent impetigo, diaper and heat rashes, raw buttocks; stops nursery odor of diapers, rubber pants, etc.
- *Helps skin disorders* – destroys bacteria which often spread and aggravate troublesome pimples and surface blemishes.

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AUBURN, N. Y.

A Secretary at Your Service

Unique program undertakes to find them, weed them, test them, train them

• Suppose your county medical society took over the chore of finding and weeding out applicants for your secretary's job. Suppose it supplied experienced girls to fill in at vacation and billing time. Suppose it kept your office aide well informed about all its services—health insurance, collections, telephone answering, and the like.

"That's for me," you'll probably say. And it *does* sound ideal.

Yet it's an ideal that's realizable. For already several county medical associations have put such a program into practice. And there's no copyright on it. You can use it in your own home town.

See how the plan operates in Milwaukee:

Whenever a doctor's assistant goes on vacation, or comes down with flu, or needs extra help at statement time, her boss simply calls on the county medical society to fill the gap. As Dr. E. L. Bernhart, the society's past president, describes it:

"These girls work out of our executive offices. Before we send any of them out alone to a doctor's office, she knows the operation of each of our departments. She answers telephones the right way. She handles people courteously and efficiently. She knows when accounts should be placed for collection."

What about the physician who needs a permanent secretary? To fill this need, the society operates a special placement bureau. All the doctor has to do is name his requirements. The bureau does the rest—locating candidates, testing them for skill in medical office work, and referring the best prospects to the physician.

The society even takes a hand in the girls' schooling. It was instrumental in starting a course in medical dictation at the secretarial school from which most local applicants graduate. There the aides-to-be also learn simple lab work and medical terminology.

As the Milwaukee society began operating such special services for members as billing, collecting, bookkeeping, telephone answering, and voluntary health insurance an unexpected problem arose: Not all local doctors fully understood the new forms and procedures. Their


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ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

"... and the drug may often be employed in cases intolerant to other antihistamines"

Every careful physician will ask about an antihistamine: "How safe is it?" Which drug, useful as an antihistaminic and clinically safe, should be a prescription of choice? • Numerous reports suggest the answer: *Neohetramine, in therapeutic doses, is one of the best tolerated of the antihistamines.*[1,2,4] Both the incidence and degree of side effects are low;[2,5] and the drug may often be employed in cases intolerant to other antihistamines.[4] Yet the usefulness of Neohetramine is clinically equivalent to that of other preparations. • Prescribe Neohetramine, for "safety first", when antihistamine therapy is indicated. Professional samples will be sent upon request.

Dosage: Average individual dose is 50 to 100 mg., 2 to 4 times daily. Children, 25 mg., 2 to 4 times daily.

References: 1. Alexander, H. L.: Postgrad. Med. 3:278 (April) 1948. 2. Bernstein, J. B., and Feinberg, S. M.: J. Allergy 19:393 (Nov.) 1948. 3. Criep, L., and Aaron, T. H.: J. Allergy 19:215 (July) 1948. 4. Friedlaender, S. M., and Friedlaender, A. S.: J. Lab. & Clin. Med. 33:865 (July) 1948. 5. Schwartz, E.: Ann. Allergy 5:770 (Nov.-Dec.) 1949.

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for effectiveness . . . for tolerance . . . in antihistaminic therapy

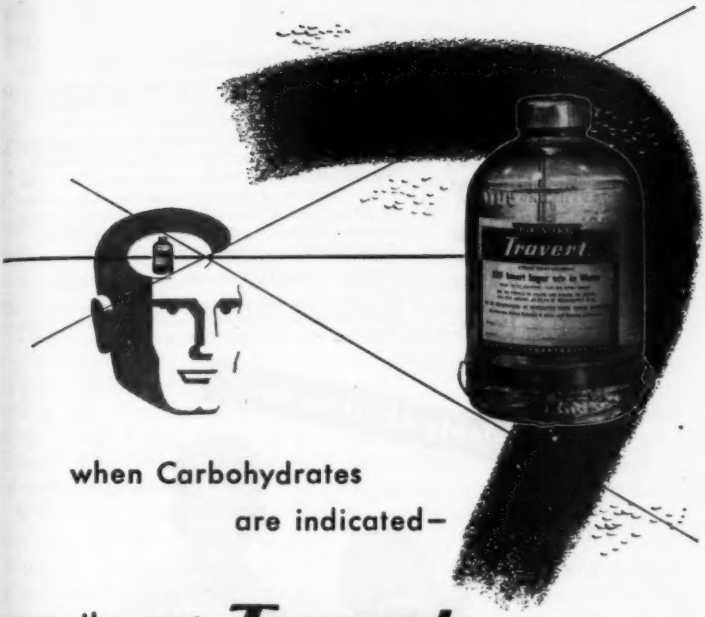
Neohetramine is marketed exclusively to physicians. It is an original and exclusive development of Nepera Chemical Co., Inc.—an organization devoted to research and manufacture of fine pharmaceutical products.

secretaries understood them even less. Mistakes were made; patient relations were damaged.

To help correct this, a group known as the Milwaukee County Medical Assistants was organized in 1945. Opposed at first by some doctors as "another union," the organization soon won their full support. Reason: Doctors now can see in their own offices the good results that stem from the exchange of ideas among these girls. Reports Dr. Bernhart:

"They have proven to be a willing corps of workers in our activities. They have improved patient-physician relationships substantially. It cost us a little money to get this organization going, but money was never better spent."

Many doctor-assistant-patient programs fall short because they're thought up and run piecemeal. In Milwaukee, an attempt has been made to round up the most helpful ideas, then coordinate them in action. Physicians and patients have benefited alike. END



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What! A Doctor Without a Hobby?

[*Continued from* 67]

have to admit that the result is "interesting." This is also a quiet hobby, and your mother-in-law has to be sensitive indeed to object to the grating of brush on canvas.

Two weeks of painting entitle you to exhibit. Being naturally lazy myself, I didn't exhibit until after two months. Yet I won first prize in the group of portraits in oil by those painting less than six months but more than six weeks.

My second entry five months later—one of a group of landscapes in oil by those painting six to twelve months—didn't even rate an honorable mention. Of course, there were 625 entrants. But there were also 623 prizes. Somebody else and I switched to another hobby.

I found myself attracted to photography because of the slogan about pressing the button and letting the camera do the rest. As a boy, I had always been adept at clicking the shutter on a box camera. As a grown-up, I learned that to get better pictures, you have to keep buying better cameras. Thus, by $40 stages, you wind up with something on the order of a $300 Leica. By simple accretion, you also have several photoflood bulbs, a flash gun, an exposure meter, tripod, film winder, projector, viewer, and screen.

At this stage, taking a picture is fairly routine. You prop your baby on a table, arrange the flood lamps, check your exposure, set your shutter and diaphragm opening, focus your camera, wait for the baby to smile—and then snap a double exposure.

Of course, you don't *always* get a double exposure. Sometimes your finger is over the lens, or you trip over the extension cords, or baby decides it simply isn't his day to smile.

When you get into this rarefied atmosphere, you realize that your films are too precious to entrust to the local drug store. So you learn to develop and print them yourself. This is something any 5-year-old can do—if he's been doing it since birth. There's nothing quite like the thrill of developing a print and seeing the image take form and darken—or even turn black. On rare occasions, of course, you do have the joy of producing a perfectly exposed print. It's just too bad that when taking the picture you cut off the baby's head.

Some lives are well-rounded by music. Despite what anyone says, I like to sing. In the movies, when they had a man at the organ and you had to follow the bouncing ball; I was always way ahead of the ball. But then, I was always a fast reader.

In my maturer years, I studied the piano but, as they say in the

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Effective Deep Heat Therapy
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Precise Electrosurgery

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For diathermy, condenser applicator pads and/or cuffs, or the inductance cable, may be easily adjusted to body contours without tapes or straps.

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Model VC-5000 is handsomely encased in a sturdy, all-steel cabinet with lasting scratch- and crack-proof enamel finish.

Standard accessories: 1 Inlet cable; 2 heavy rubber condenser pads, 7" x 10"; 1 inductance cable; and 4 heavy, perforated felt spacers, 8"x11".

Size of unit: approx. 15" high, 14" wide, 17" deep.

Write for descriptive literature

American Cystoscope Makers, Inc.

1241 LAFAYETTE AVENUE — FREDERICK J. WALLACE, President — NEW YORK 59, N. Y.

ads, when I sat down they laughed. Later, I sort of nibbled at a recorder. Often I could even recognize the tune I was playing. The main trouble: It was always so darned cold down there in the cellar.

Some medicos develop enough musical talent to play in a doctors' orchestra and give concerts. At these affairs about fifty doctors play to an audience of about 150 listeners. That's because the average family numbers four persons.

A popular avocation is card-playing. This hobby can be both social and anti-social. That is, it is pleasant to play with those you like and a relief to play with those you don't want to talk to.

I became quite a proficient player, but I was always a little out of step. When I finally learned casino, everyone else was playing poker. When I mastered poker, my friends were playing auction bridge. I learned auction just as everyone switched to contract bridge. Now I'm good at contract, but wherever I go they play canasta. So I play the television set.

Some don't regard reading as a hobby; but I do since it, too, is part of the well-rounded life. I belong to the Book-of-the-Month Club, the Book Find Club, the Book Classics Club, and the Limited Editions Club. I buy the Atlantic Monthly and Harper's plus several *avant-garde* magazines, at least one of which seems to fold each month.

All these I subscribe to. What do I actually read? Detective stories and magazines with pictures.

Reading is naturally a great social asset. In any group, when a best-seller is discussed, I can confidently assert that I have the book. As a matter of fact, I can recall that it is a blue-bound volume with white lettering; that it was the May choice of the Book Lovers League, along with their dividend, "Guide to Gloxinia Gardening"; and that it is the third book on the second shelf, along with my other blue books.

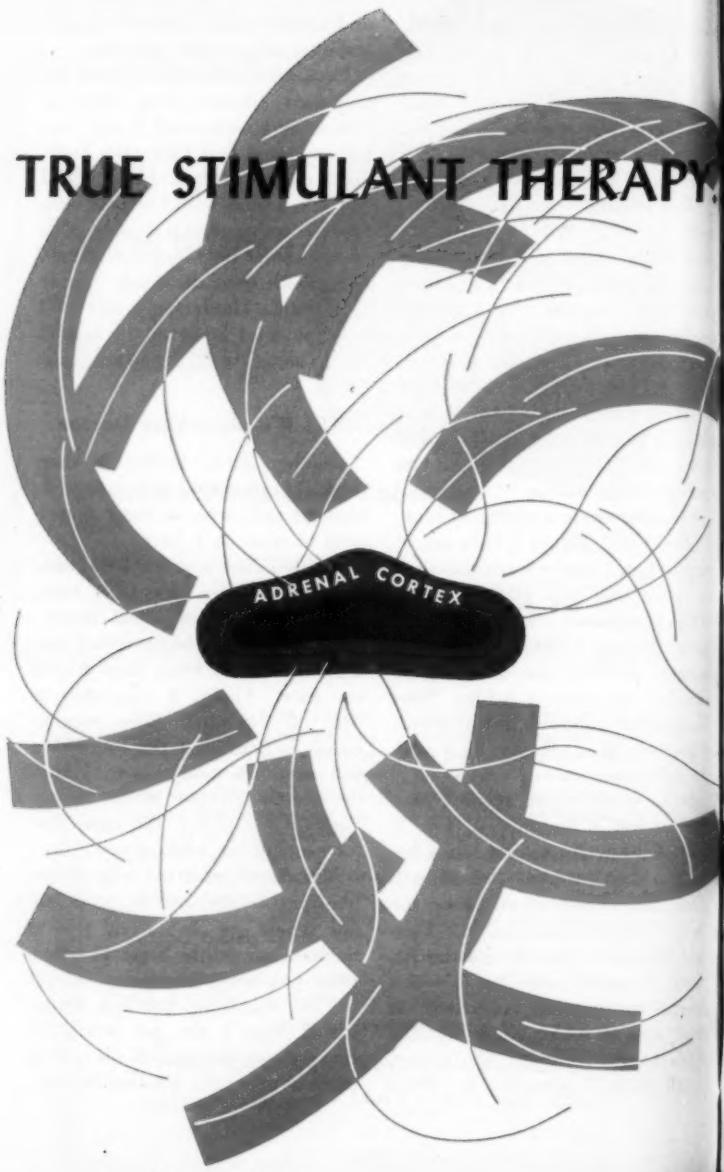
The Woodworking Doctor

Another great hobby is shop work. I recommend it to any red-blooded man with as many fingernails to spare as I have.

At my initial attempt, I was able to make a really acceptable table with three legs of equal length. The fourth leg, though, defied me. First it was too long; then it was too short. Finally I was able to trim off the other three legs to equal measure—but the fourth leg still wouldn't match. Now, I find, the March selection of the Newer Poetry Club is just the right size for keeping the table steady.

Woodworking is not only an interesting hobby but a profitable one. There are always odd jobs to be done around the house or office. Why pay some handyman a stiff fee for something *you* can do instead? Many's the job worth $5 that you can do yourself for just 15 cents in materials. The only trouble

TRUE STIMULANT THERAPY...



ACTHAR represents the natural stimulus for the adrenal glands to secrete the entire spectrum of cortical hormones at a rapidly increased rate. Thus the role of ACTHAR is to provide true stimulation therapy in a wide variety of diseases. ACTHAR neither substitutes nor replaces individual cortical hormones. Mobilization of physiologic mechanisms accounts for the safety of ACTHAR and permits prolonged courses of treatment without rest periods.

ESTABLISHED INDICATIONS: Rheumatoid arthritis, rheumatic fever, acute lupus erythematosus, severe asthma, drug sensitivities, contact dermatitis, most acute inflammatory diseases of the eye, acute pemphigus, exfoliative dermatitis, ulcerative colitis, acute gouty arthritis and secondary adrenal cortical hypofunction.

Literature and directions for administration of ACTHAR, including contraindications, available on request.

ACTHAR is available in 10, 15, 25 and 40 milligram vials.

ACTHAR

ARMOUR LABORATORIES BRAND OF ADRENOCORTICOTROPIC HORMONE (A.C.T.H.)

THE ARMOUR LABORATORIES

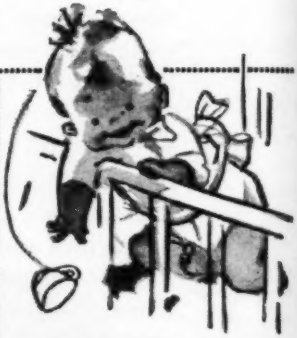
CHICAGO 11, ILLINOIS

PHYSIOLOGIC THERAPEUTICS THROUGH BIORESEARCH

Delicious Dessert For Your Tiny Patients...

Heinz Strained Pears

One Of The Most Delightful Fruits That Ever Tempted A Baby!



FRESH and inviting in flavor—satin-smooth in texture—Heinz Strained Pears add welcome variety to the menus of your youngest patients! The true, naturally sweet taste of choice-of-the-crop Bartlett or Winter Nellis Pears is delicately heightened by the deft use of lemon juice and sugar.

Heinz Strained Pears are scientifically cooked and packed to assure high retention of vitamins and minerals. *All* Heinz Baby Foods—over 40 kinds—are prepared with the same care. That's just one reason why they deserve your recommendation!

HEINZ makes a complete line of baby foods for your youngest patients! These quality products include—

Pre-Cooked Cereal
Pre-Cooked Oatmeal
Strained Baby Foods
Junior Baby Foods

—every one outstanding for flavor, color and texture!

An 82-Year Reputation Backs the Complete Line of

Heinz Baby Foods

CEREALS • MEATS • DESSERTS
FRUITS • VEGETABLES

is, before you finish the 15-cent job, you'll probably have to buy some special $10 tool.

Collecting is another splendid hobby. It appeals to the squirrel in us. Of course, I disbelieve completely the reasons a man gives for collecting particular items, whether they be butterflies, buttons, or birds' nests. I know full well that if his entire collection were destroyed, he'd soon be back collecting something else.

The Collecting Doctor

Of all the collecting manias, stamp collecting is the most widespread and benign. I started this hobby as a child, when I felt complimented at getting "free of charge a thousand all different selected stamps from seventy-six mysterious and exotic countries sent only to serious and mature individuals requesting approvals."

Of course, the thousand stamps never *were* all different. Nor did I consider the one-, two-, and three-cent stamps from the United States as the product of a "mysterious and exotic" country. Now, twenty years more serious and mature, I'm still sending for their approvals. But not so often. I had to slow down after developing a glossitis trying to keep up with governmental issues.

For physicians, a really great hobby is fishing. It automatically places you out of reach of telephones and in the open air. You can spend more time in contemplating fishing and readying yourself and your equipment than you can in fishing itself. Best of all, catching a fish is not a prerequisite. This is good for the duffer like myself who perpetually loses in any battle of wits with a three-inch perch.

The Gardening Doctor

Gardening is a tempting hobby for many, though I've never seriously tried it. I'm one of the few individuals who cannot get petunias to survive in a flower pot. In my hands, narcissus bulbs rot, snake plants wither, and Chinese lilies turn yellow and collapse. I refuse to contemplate what would happen if I had access to a vegetable or flower garden. My zeal for gardening is further diminished when I hear my horticultural colleagues discuss blights, insects, and fertilizers.

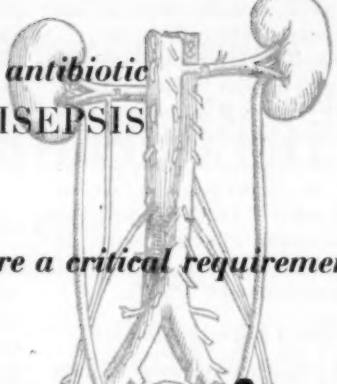
The praise of a wonderful tomato that cost only 45 cents (discounting labor) gives me pause, I'll admit. But I'm putting temptation away by having my lawn and yard paved.

There are other hobbies—too many even to enumerate in a short article. And you, dear reader, should have one. But for me, no. I'm tapering off. Ahead lies the sweet emancipation of hobbylessness. I wouldn't take the world's best hobby in exchange for the hours I now spend sitting around in a dull funk.

—THEODORE KAMHOLTZ, M.D.

In the selection of an antibiotic for URINARY ANTISEPSIS

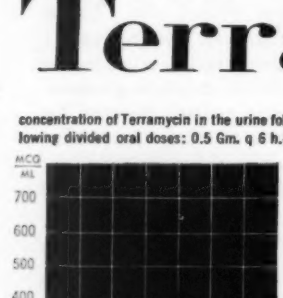
high urinary levels
rapidly achieved
and easily maintained
are a critical requirement



CRYSTALLINE Terramycin

HYDROCHLORIDE

concentration of Terramycin in the urine following divided oral doses: 0.5 Gm. q 6 h.[3]



This newest of the broad-spectrum antibiotics is stable and active in the urine. High levels are rapidly achieved and easily maintained by oral administration. Within one-half hour after a single 2 Gm. dose, detectable amounts have appeared in the urine,[1] and a single 0.5 Gm. dose has been shown to produce high concentrations lasting twenty-four hours.[2] When multiple doses are given, continuous urinary concentrations of Terramycin in the range of 300-400 mcg./ml. are obtained, as shown in the accompanying chart.[3]

These observations are given added significance by the highly satisfactory clinical experience and the prompt response obtained with Terramycin in a wide range of infections of the urinary tract.

Supplied: 250 mg. capsules, bottles of 16 and 100;
100 mg. capsules, bottles of 25 and 100;
50 mg. capsules, bottles of 25 and 100.

1. Schoenbach, E. B.; Bryer, M. S., and Long, P. H.: Ann. New York Acad. Sc. 53:245 (Sept. 15) 1950.

2. Welch, H.; Hendricks, F. D.; Price, C. W., and Randall, W. A.: J. A. Ph. A. (Sc. Ed.) 39:185 (Apr.) 1950.

3. Welch, H.: Ann. N. Y. Acad. Sc. 53:253 (Sept. 15) 1950.

Antibiotic Division Pfizer *Chas. Pfizer & Co., Inc., Brooklyn 6, N.Y.*

They Settle Doctor-Patient Disputes

[*Continued from* 63]

One woman, for example, calls the medical society periodically, threatening to unleash a story "that will shake the medical world." She claims to have been "wrecked" by ten of the county's physicians. But she always hangs up before going into the toothsome details or revealing her name.

Another—a middle-aged, ex-follies girl on relief—developed a crush on a doctor who was treating her arthritis. She barraged him with poetic mash notes. Hearing about this, the medical director of the local welfare department shifted her to another doctor. She now badgers the medical society to do something about "the plot against me."

A woman with two children recently wrote to the medical society "in great desperation." Her husband had been too sick to hold a steady job for the past five years. He had gone to a number of doctors but none would help him. Couldn't the medical society look into his case?

Inquiry showed that the man was undoubtedly a hypochondriac. He had been admitted to several hospitals and clinics. Repeated tests had failed to show anything wrong with him. The conclusion reached by several doctors who had examined him: He was using an imaginary illness as a defense for not supporting his family. Social Worker Russell visited the man several times, finally persuaded him to go to a clinic for psychiatric treatment.

Since most disputes hinge on doctor-patient misunderstandings and are easily settled, few get as far as the grievance committee. "The real value of this committee is its mere existence," says Dr. David Fertig, the society's public relations chairman. "Knowing that their problems will get a fair review means a lot to the public."

Of the eight cases handled by the grievance committee so far, five have been decided in favor of the doctor, three in favor of the patient. In each case, the doctor has willingly appeared before the committee.

When a Doctor Balks

What happens if a doctor refuses to abide by its decision? The committee has no enforcement power, but it does have persuasive appeal. Consider this case:

A young housewife called her doctor, complaining of abdominal pains. When he got around to seeing her a day or two later, he made a quick examination and prescribed medication for influenza. The following day she had to be rushed to the hospital with a ruptured appendix, almost died. The surgeon's fee was $200 and the family doctor

submitted a bill for the same amount. Whereupon her husband contacted the medical society.

After reviewing the facts, the grievance committee suggested that the G.P. cut his bill sharply. He answered by threatening the patient with suit.

Meeting a second time, committee members set a fee of $100. "We have no legal right to set fees," they told the doctor, "but we have a moral right to protect the public." The patient agreed to pay the $100. But the doctor defied the committee, went ahead with plans to sue.

The committee then decided to crack down. The society's counsel contacted the doctor's lawyer, told him that grievance committee members would testify *against* the doctor if the case came to court. It never did.

Settling fee disputes out of court and thus averting bad publicity for doctors is one of the major aims of the society's over-all program. Its Bureau of Medical Economics, which collects members' delinquent accounts, plays a big part in bringing such disputes out into the open before they cause trouble.

Shortly after the bureau got underway last October, for example, Manager Fred Gardner got a call from a doctor: "I've been planning to sue a patient who refuses to pay a $500 account," he said; "but before I go ahead I'd like to see what the bureau can do."

A quick check by the bureau's field man revealed that the patient, a prominent man in the community, felt the bill was unreasonable. The bureau suggested mediation by the grievance committee. But the physician and the patient agreed in writing to accept the committee's decision.

"We've found," says Manager Gardner, "that people who don't pay their medical bills usually harbor some resentment toward their doctors. Often they feel a bill is too high, or they're dissatisfied with the treatment. Actually it's more important to us to straighten out the misunderstanding than to collect the money."

Collection Results

All the same, the bureau has chalked up a pretty good collection record, as witness these results:

In its first three weeks of operation, it collected (1) a $1,000 account in full; (2) several accounts over five years old; (3) several that were returned to physicians by commercial agencies as uncollectible; (4) a big part of seventeen accounts from one physician. In its first three months' operation alone, the bureau collected 21 per cent of all delinquent accounts referred to it.

One $25 account, owed by an elderly woman, was eight years old when turned over to the bureau. Yet a single letter from the bureau brought the woman in with the full amount. She hadn't been able to pay at first, she explained. Then she

had become irritated at the attitude of a commercial agency that had tried to collect. She had resolved not to pay, but changed her mind after hearing from the society.

Another patient, in settling a back bill with the bureau, insisted on paying the bureau's commission* "so my doctor will receive his full fee."

Suppose a patient claims he's unable to pay the entire bill. And suppose, after an investigation, the bureau agrees. It then suggests to the doctor that the bill be scaled down. Usually the M.D. does so.

Sometimes, of course, patients feign inability to pay. Like the man who said he could afford only $1 a month on a $24 debt. It turned out that his yearly income was $7,000. When the bureau confronted him with this fact, he owned up and raised the ante.

Such cases, however, are infrequent. Says Manager Gardner: "It's gratifying to see how fair most people really are—if they think *you're* being fair with *them.*"

*Twenty-five per cent for accounts of $20 or more that are less than six months old; 33 1/3 per cent for such accounts six months to a year old; and 40 per cent for accounts under $20 or over a year old.

Malpractice Protection

This effort to settle doctor-patient disputes in a way that will keep both parties happy is, of course, bound to result in fewer malpractice suits. Already, two patients who felt they had grounds for suit have asked the medical society whether they should take legal action. At the society's suggestion, both have agreed to put their problems before the grievance committee instead.

It's cases like these that led one old-school Westchester M.D. to remark recently: "I'll admit I was far from sold on the program at first. It seemed to me that a $15 hike in annual dues was a pretty steep price just to mollycoddle chronic complainers and malcontents. But you know, I'm beginning to think we've really got something here."

—ROGER MENGES

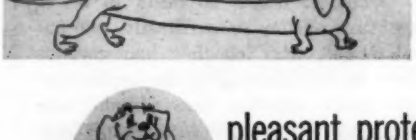
Feminist

• The patient explained that she'd been suffering abdominal and low back pains. "My neighbor, Mr. Willoughby, had exactly the same symptoms before he came to you, Doctor. I'm sure if you just give me whatever you gave him, I'll be fine again."

Delicately I revealed that in Mr. Willoughby's case it had been less blessed to give than to take away—his prostate gland.

—M.D., CALIFORNIA

powerful protection



prolonged protection

pleasant protection

with **Bactine**

BRAND · Reg. U.S. Pat. Off.

versatile antiseptic

powerful protection—Bactine is effective against most pathogenic bacteria, gram negative and gram positive, and against at least 14 types of common fungi. Even a dilution as high as 1:4000 of BACTINE keeps Staphylococcus aureus from growing or multiplying.

prolonged protection—Bactine keeps surfaces actively antibacterial for more than 4 hours despite re-contamination. Hands that had been washed in BACTINE gave a zero count for micro-organisms after 40 minutes in rubber gloves; hands washed in 70 per cent alcohol gave a bacteria count of 767,000 after the same period in rubber gloves.

pleasant protection—Bactine is gentle to tissues and practically painless on abrasions and cuts. It has a clean, fresh odor and does not stain.

some of Bactine's many uses

- Hand disinfectant
- First aid, burns, etc.
- Disinfectant for instruments
- Sanitizing sickroom
- Backrub, massage
- Preparation of skin for surgery

- Bactericide
- Deodorant-detergent
- Fungicide
- Antipruritic

MILES LABORATORIES, INC. ELKHART, INDIANA

G.P.'s Get P.G. Instruction by Phone

Indiana pioneers a statewide educational hook-up that might work in your state

• With thirty-eight of his G.P. colleagues, Dr. Howard Byrnes sits in the hospital conference room, ready for a new sort of post-graduate class. He scans his sheaf of advance material: photographs of tonight's speakers, outlines, charts, tables. Promptly at 8 P.M., the moderator's voice—from the loudspeaker up front—halts the shop-talk.

"Before we discuss 'Carcinoma of the Cervix,' we have an interesting question from Dr. Byrnes of Harrodsburg on last month's subject. It involves bacterial sensitivity tests and . . ."

This scene is duplicated in twenty-eight or more Indiana counties, where upwards of 800 Hoosier physicians are simultaneously getting the same instruction—by long-distance telephone. In Indianapolis, at the center of the state-wide hook-up, the moderator and three top-notch speakers sit around a table at the Indiana University School of Medicine. Talks and discussion last for one hour.

Do P.G. classes via party line really work? The Indiana State Medical Association, which sponsors them, says yes—so far.

Speakers are enthusiastic, and Indiana medical men by and large agree. Sample comments: "This plan is the best I've seen in operation" . . . "The method of presentation is excellent and is much preferred to one man speaking on one subject... "Best way I know of bringing the best to us at the least expense."

What about costs? Aren't line changes pretty stiff? They are. The *total* cost of the series, when the state's ninety-two counties are all covered, is estimated at more than $1,000 per hour. But when this is divvied up among the many doctor-listeners, it's a different story. At present, each man's cash outlay per program is only 50 cents. He pays $2.50 for the current series of five monthly classes (January through May).

Besides collecting each member's share, the county society foots the bill (about $7.50) for the line from the local telephone office to the meeting place—and for the hire of an amplifier-speaker. The state association pays for printing and distributing visual materials. The speakers work free.

One big advantage, of course, is

NEW THERAPY FOR SINUSITIS RHINITIS

Reasons for the clinical effectiveness of Furacin include: a wide antibacterial spectrum, including many gram-negative and gram-positive organisms—effectiveness in the presence of wound exudates—lack of cytotoxicity: no interference with healing or phagocytosis—water-miscible vehicle which dissolve in exudates—ability to minimize malodor of infected lesions—low incidence of sensitization: less than 5%—stability.

Contains Furacin 0.02% brand of nitrofurazone N.N.R. and ephedrine • HCl 1% in an isosmotic, aqueous vehicle.

Excellent results are being obtained with Furacin Nasal in cases of acute and chronic sinusitis and rhinitis. It is being administered by dropper, atomizer, cannula or the displacement technic.

Even those notoriously refractory conditions: atrophic rhinitis and ozena* show marked benefits from Furacin therapy.

*Thornell, W. C.: Arch. Otolaryng. 52:96 (July) 1950.

Literature on request

Furacin® Nasal with ephedrine

E·A·T·O·N Inc.
LABORATORIES
NORWICH, NEW YORK

that travel time and expense are cut—for G.P.'s and speakers alike Dr. Q, who is sweating out a delivery, can still spare a couple of hours for the session and stay on call. The university's professor of pathology doesn't spend hours driving on winter roads for a lecture in another corner of the state.

What's more, the latter doesn't have to give repeat performances. A recording is made of each seminar. Local societies that missed the live program can rent the recording for 50 cents per active member.

Does absence of an in-the-flesh speaker make a difference? A majority of the doctors apparently think not. In fact, one society reports: "We had a much better attendance than if the speaker had been here." Of course, when the novelty wears off, this factor may have an opposite effect.

Two major drawbacks of the remote-control P.G. courses are being overcome. One is lack of visual material. You can't hold a "wet clinic" by wire. But listeners *can* follow the unseen speaker with mimeographed charts and outlines—and that's how the Indiana association is filling the gap.

The other flaw is lack of a question period. To get around this, Dr. X can now mail in his questions beforehand; they're incorporated in the program. Dr. Y, whose questions popped into his head *during* the seminar, may also send them in; they'll be answered by mail or during the next session.

The Indiana project is the brainchild of Dr. Harry E. Klepinger of Lafayette. He based it on the University of Illinois' four-year-old telephone course for dentists.

As 1950 chairman of the state association's committee on medical education, Dr. Klepinger found that the usual methods of P.G. education weren't panning out. Full-scale regional meetings and one-night stands weren't drawing the mass of physicians. He needed a fresh idea—and this was it.

On October 3, he ran a test program from the medical school in Indianapolis to the staff of St. Elizabeth's Hospital in Lafayette, 60 miles away. Of the 105 doctors who listened in, ninety-seven hailed the idea enthusiastically. Promotion to the local societies followed.

By November 7, Indiana was ready for its first P.G. class by telephone network. Five Indiana Uni-

"How do these tonsils look?"

versity faculty members dealt with autonomic drugs, veratrum alkaloids, ACTH, cortisone, and NPH insulin. The audience: 472 physicians in thirteen counties.

For the December session, the audience almost doubled—to twenty-four societies and 752 members. So, still feeling its way, Indiana is full of hope that it has a new solution to an old problem. Says James A. Waggener, field secretary of the state association: "If we can continually improve the quality of our programs, interest in P.G. education will reach a new high in our state."

By way of improving quality, the society is beginning to add out-of-state speakers to its telephone network. Last month, for example, two authorities on heart disease talked from Brookline, Mass.: Dr. Howard Sprague, president of the American Heart Association, and Dr. Sam A. Levine, professor of clinical medicine at Harvard Medical School. Two other heart experts were heard from Rochester, Minn.: Dr. Arlie Barnes and Dr. Edgar Allen, both of the Mayo Foundation. The moderator cued them in from Indianapolis.

Is the scheme practical for other states? Line costs vary, of course, depending on the size of the state. Without a centrally located medical school where most instruction could originate, such expenses might be too high. But Indiana has shown that most of the apparent difficulties can be ironed out. END

HELPING YOUR GERIATRIC PATIENTS COMBAT BILIARY DYSPEPSIA AND CONSTIPATION

The high incidence of biliary tract disorders* focuses attention on the hepato-biliary system when patients past age 40 complain of gastrointestinal discomfort, flatulence, and constipation. Caroid and Bile Salts Tablets assure effective relief of retarded intestinal function in aging patients by—

1. *stimulating bile flow*
2. *improving digestion and absorption of foods*
3. *gentle laxation without whipping the bowel*

—thereby aiding reestablishment of peristaltic function

DOSAGE: 1 or 2 tablets after breakfast and at bedtime with a glass of water.

Samples available on request

AMERICAN FERMENT COMPANY, INC.
1450 Broadway, New York 18, N. Y.

*Rehfuss, M. E.: Penna. Med. J. 42:1335, 1939

CAROID AND BILE SALTS *tablets*

Specifically indicated in biliary dyspepsia and constipation

Will You Get Social Security?

New provisions may help some doctors offset inflation's dent in retirement plans

● At first glance, you may not see much of interest in the recently revised Social Security Act. For physicians in private practice were specifically excluded when 10 million more people were brought under coverage Jan. 1.

But salaried medical men have a direct interest in Social Security. Many of them will some day be eligible for benefits—benefits that can be attractive enough to make other doctors sit up and take notice.

Consider the case of an Eastern G.P. He had planned to give up his private practice and retire when he reached 65. The time was only two years away. But inflation had created a big gap betwen the amount he'd need as retirement income and the amount his annuities would provide.

When he read about the new Social Security provisions, he suddenly realized they offered him a way to bridge the gap. He'd always devoted a day or two a week to part-time salaried work. Currently he spends three days a week examining new employes in a near-by war plant. Here's what this means to him in the light of the new Social Security law:

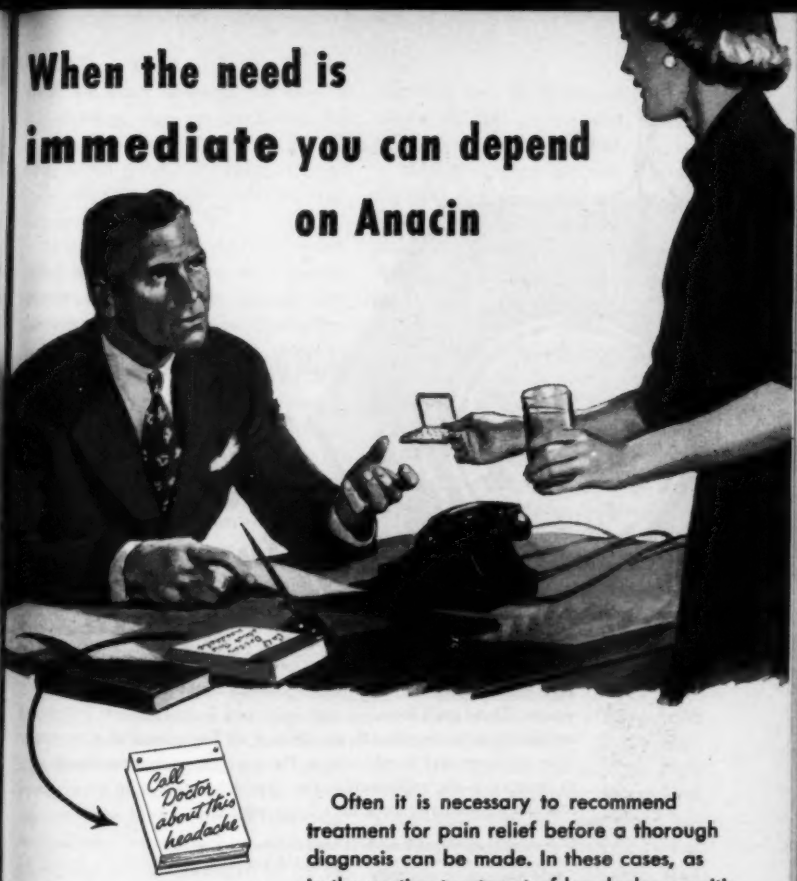
Since he'll earn more than $300 a month in part-time salary for the next year and a half, he'll be entitled to maximum benefits after he's 65. When he retires, he'll draw $80 a month for life—plus another $40 a month for his wife when she reaches 65. Social Security payroll taxes for those eighteen months will set him back $81.

Consider another case—that of a salaried pathologist in a Midwestern hospital. He'll be eligible for maximum Social Security benefits in six years. To collect them, he must stop working in covered employment; but that doesn't mean he'll have to give up medicine altogether. He plans to quit his hospital job at 65 and go back to private practice. He'll draw his monthly retirement checks just the same. His total cost in payroll taxes: $378 over a six-year span.

Only physicians in the close-to-retirement age group can reap benefits on this scale. Many salaried employes who pay Social Security taxes will never get back a nickel in retirement checks.

Take almost any young resident

When the need is immediate you can depend on Anacin



Often it is necessary to recommend treatment for pain relief before a thorough diagnosis can be made. In these cases, as in the routine treatment of headache, neuritis and neuralgia pain, you can depend on Anacin. These tablets afford all the advantages of quick, long lasting analgesia characteristic of the time tried and proved APC formula. Anacin is well tolerated too, preferred by many who experience gastric upset from other analgesics. For your patient's convenience, Anacin is available at all pharmacies. If you would like to receive samples of Anacin, please send us your request on your letterhead.

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Just 4 small doses provide

'Round-the-clock relief for allergic patients

Long-lasting relief[1] . . . low milligram dosage[2] with few side actions. These are advantages you *expect* in a professional antihistamine for use in difficult allergies, or for patients who have not responded to other drugs. These advantages are *combined* in Decapryn—the antihistamine that provides a good night's rest and a good day's work for allergic patients.

1 "Symptoms were relieved from 4 to 24 hours after the administration of a single dose of Decapryn—" . . . Sheldon, J.M. Et al: Univ. Mich. Hosp. Bull. 14:13-15 (1948)

2 "It was found that 12.5 mg. could be given during the day with comparatively few side reactions and yet maintain good clinical results—" . . . MacQuiddy, E.L.: Neb. State M.J. 34:123 (1949)

DECAPRYN®

The long-lasting, low-dosage prescription antihistamine

DECAPRYN (DOXYLAMINE) SUCCINATE

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CINCINNATI • U.S.A.

Available on prescription only, as pleasant-tasting liquid, or palatable tablets

in a voluntary hospital. He may, if he chooses, sign up for Social Security coverage. But it won't do him much good if he intends to go into private practice when his residency ends.

Why? Because of the way retirement benefits are figured. A person 62 or over needs only six calendar quarter-years in covered employment to be eligible for monthly checks at 65 (or whatever age after that he retires). But a person 45 or under needs forty calendar quarter-years—a mighty long residency.

Insurance Benefits

Retirement benefits, of course, are only one side of the Social Security picture. A fair amount of life insurance protection is also provided. Here's how it works:

Suppose a salaried doctor dies, leaving a wife and a 3-year-old son. Assuming he's entitled to maximum benefits, his widow will get a lump-sum death payment of $240. She'll also receive $60 a month until her dependent son reaches 18—provided she doesn't remarry or go to work in the meantime. The son also will draw $60 a month for fifteen years. Payments to the widow will be resumed when she reaches 65 if she's still unmarried.

How much does Social Security cost the insured physician? If he's a salaried worker of 50, he now pays $54 a year on his first $3,600 of income. Starting in 1954, the tax rate will be upped again. By the time he's 65 he'll have paid out about $1,200—an amount his employer will have matched.

Which doctors are now covered by Social Security? Some of them work for profit-making organizations: insurance companies, pharmaceutical houses, and a few hospitals and rest homes. This group, in general, has been covered since 1937. (Not included here are physicians who occasionally conduct physical exams on a fee basis for industrial or commercial firms. They're considered private contractors, not employes.)

Workers in nonprofit organizations such as colleges, research foundations, and most voluntary hospitals have been included on an optional basis since Jan. 1. (Coverage is mandatory for an employe who joins an organization *after* a plan has been set up.)

So far, medical men have been hesitant about joining. At the Hospital for Special Surgery in New York City, for example, 85 per cent of all employes are enrolled; but the roster includes no residents and only a few of the salaried staff physicians.

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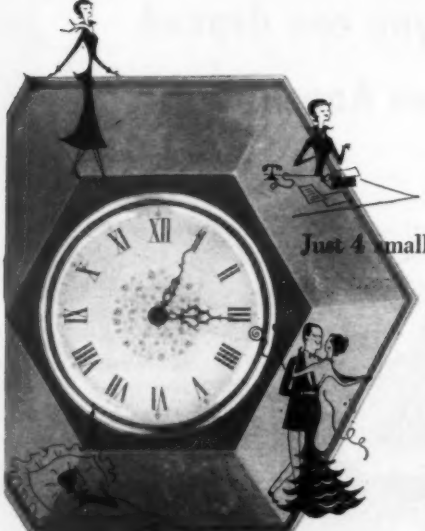

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'Round-the-clock relief for allergic patients

Long-lasting relief[1] . . . low milligram dosage[2] with few side actions. These are advantages you *expect* in a professional antihistamine for use in difficult allergies, or for patients who have not responded to other drugs. These advantages are *combined* in Decapryn—the antihistamine that provides a good night's rest and a good day's work for allergic patients.

1 "Symptoms were relieved from 4 to 24 hours after the administration of a single dose of Decapryn—" . . . Sheldon, J.M. Et al: Univ. Mich. Hosp. Bull. 14:13-15 (1948)

2 "It was found that 12.5 mg. could be given during the day with comparatively few side reactions and yet maintain good clinical results—" . . . MacQuiddy, E.L.: Neb. State M.J. 34:123 (1949)

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in a voluntary hospital. He may, if he chooses, sign up for Social Security coverage. But it won't do him much good if he intends to go into private practice when his residency ends.

Why? Because of the way retirement benefits are figured. A person 62 or over needs only six calendar quarter-years in covered employment to be eligible for monthly checks at 65 (or whatever age after that he retires). But a person 45 or under needs forty calendar quarter-years—a mighty long residency.

Insurance Benefits

Retirement benefits, of course, are only one side of the Social Security picture. A fair amount of life insurance protection is also provided. Here's how it works:

Suppose a salaried doctor dies, leaving a wife and a 3-year-old son. Assuming he's entitled to maximum benefits, his widow will get a lump-sum death payment of $240. She'll also receive $60 a month until her dependent son reaches 18—provided she doesn't remarry or go to work in the meantime. The son also will draw $60 a month for fifteen years. Payments to the widow will be resumed when she reaches 65 if she's still unmarried.

How much does Social Security cost the insured physician? If he's a salaried worker of 50, he now pays $54 a year on his first $3,600 of income. Starting in 1954, the tax rate will be upped again. By the time he's 65 he'll have paid out about $1,200—an amount his employer will have matched.

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M.D.s' Charity Work Finances Society

Part payment by townships and county for doctors' care of indigent defrays bulk of society's expenses

● Do you do a slow burn when your local medical society keeps levying special assessments? Then listen. Here's a system of painless financing worked out by the doctors of a 200-member society—a plan that has just about quadrupled the society's income.

Four years ago the Vanderburgh County (Ind.) Medical Society decided to expand its public relations program. But with only 200 members to pay the bill, the load on each promised to be a heavy one. Even after yearly dues were jacked from $15 to $35, there still wasn't enough money to do the PR job, along with everything else.

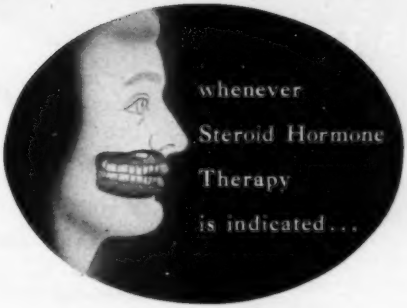
Then one of the members had an idea. Why shouldn't the various townships in the county pay the society for the charity work done by society members in the county's three general hospitals? The proposed payments would be mere tokens of the true value of the Vanderburgh doctors' services (estimated at $100,000 a year). Nevertheless, they would help the society to solve its financial problems and, at the same time, render a better public service.

Adopting the idea would mean a sharp break with tradition; for Vanderburgh doctors had never before charged for hospital charity cases. Backers of the idea argued, however, that individual M.D.'s still wouldn't make a cent. And the society could use the money it took in this way to aid all the people of the county—not only the medical profession.

Local physicians then sounded out public opinion on the plan. It was almost entirely favorable. In fact, most people thought the doctors were *already* getting paid for charity work.

Trustees for It

Township trustees, instead of fighting the idea, were quick to see that it might even *save* them money in the long run. One of their main aims was to avoid unnecessary expense in the treatment of charity patients. But no economy drive could succeed without active support from the physicians. What better way to get this support than to agree to their plan? [*Turn page*]



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save money for the Patient

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The use of Linguets thus makes possible satisfactory therapeutic response with low dosages. "Manifestly, this represents a great financial saving to the patient . . ."[1] and "reduces the office load on the busy practicing physician."[2]

2/1651M

1. Escamilla: R. F.: Am. Practitioner 3:425, March, 1949
2. Lisser, H., et al.: Postgraduate Med. 8:393, Nov., 1950

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methyltestosterone
5 mg., white—10 mg., yellow

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**For treating prostatic carcinoma only*

Percorten®
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In July 1947, a contract was signed with the township trustees. By it the medical society was to get a fixed amount of $13,400 a year for the charity work its members did in the hospitals. In return, the doctors agreed to practice every sensible economy when treating indigents. Among other things, this meant using fewer expensive drugs, keeping hospital days per patient to a minimum. (A year after the contract had been drawn up, township officials estimated they had saved $20,000 through the doctors' economies.)

In January 1950 the society reached a similar agreement with the county welfare department. This one called for payments of $3,600 a year—making a total of $17,000 in token payments from county and townships. This amount, plus dues and lesser income, gave the society a 1950 income of about $24,000.

How did the doctors use the money?

About $15,000 went toward the society's regular operating expenses. Some $5,500 was used for public relations. And $3,500 was put into a reserve fund.

Besides bolstering the society's treasury, the plan has changed some members' thinking about charity contributions. "Many of our men," says Executive Secretary Arthur P. Tiernan, "were using charity work as an excuse for not supporting the Community Chest and other worthwhile enterprises." Now this attitude has changed—and community leaders no longer criticize M.D.'s for their lack of generosity. Last year, Vanderburgh physicians gave about $10,000 to the Community Chest—twice what they gave in 1947. Their donations to all charities came to much more than the society received in payment for their charity services.

The enlarged public relations program really hit its stride in 1950. As its major projects, the Vanderburgh society:

¶ Sponsored a radio program for twenty-six weeks. Says Mr. Tiernan: "Instead of just rapping socialized medicine, we stressed the good things medicine has done for the people." Cost: $1,200.

¶ Ran a full-page ad in a Sunday newspaper to celebrate its

105th anniversary. Here too, the emphasis was on the accomplishments of voluntary medicine. Cost: $650.

¶ Continued to foot the bill for a round-the-clock, emergency medical service. This included paying the fee of the telephone answering service that handles the emergency set-up. It also included an outlay for advertising the service in the classified telephone directory and via printed announcements. Total cost: $500.

Other Projects

A number of less expensive projects rounded out the society's 1950 program. During American Diabetes Week, local doctors collected and tested more than 2,000 specimens without charge. In the fall they distributed several different types of pamphlets about socialized medicine—each type slanted toward a specific occupation or profession.

Some projects the group supports seem only loosely connected with public relations. But Mr. Tiernan explains how this liberal policy pays off. Last October, for example, the society paid for a tea given by its women's auxiliary for representatives of other county women's groups. Outside speakers, recruited for the occasion, gave socialized medicine a thorough raking-over. Result: the guests told their own groups what they'd heard—and more than 100 resolutions condemning socialism were subsequently passed. END

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1. Press [redacted] vial cap.

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Drug and diluent in one vial for instantaneous *automatic* preparation.

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Minimizes preparation time, labor and expense.

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Complete protection at the preparation stage. No air contamination.

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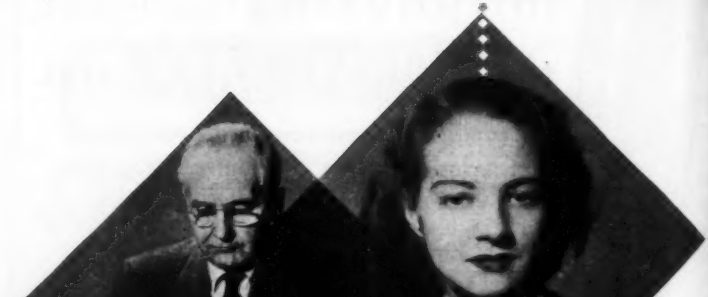

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MERLE L. YOUNGS, PRESIDENT

How to Survive a Cross-Examination

[*Continued from* 59]

Having studied a little medicine the night before, the attorney begins by trying to raise a doubt in the minds of the jurors as to the fundamental ingredient: Did the accident really cause this condition? Are there other things that may have caused it?

Q. From this woman's X-rays, you found positive findings of a fractured coccyx?

A. Yes.

Q. And you formed the opinion that it was a recent fracture caused by the accident?

A. That's right.

Q. Now you know, don't you, Doctor, that this woman gave birth to a child a couple of months before the accident?

A. I delivered the baby.

Q. Won't you agree, then, that delivery of a baby may be a cause of such a fracture and that X-ray findings following the accident need not necessarily reveal a recent fracture?

Suppose your answer is, "No—I do not agree." What is the attorney's position then? For the moment, he's stuck with *your* statement of the medical proposition—until he can discredit your opinion by confronting you with a contrary opinion of an acceptable medical authority. Such medical authority must be acceptable not merely to him, but to *you* as well.

Assume, for example, that the attorney reaches under the counsel table and comes up with Weatherbottom's text on the subject, plus the question: "Now, Doctor, you recognize Dr. Weatherbottom as a leading authority on the subject, don't you?" Should your answer be, "Sorry, Counselor, I never heard of Dr. Weatherbottom," then *that* textbook goes back under the table. It can't be used on your cross-examination.

But that may not be the end. He may then ask *you* to name some recognized authorities in the field. When, finally, you mention Dr. Smith's tome, "Traumatic Affections of the Spine," he may produce that one from his briefcase. And, by way of prelude, he will proceed to build up in the eyes of the jury the infallibility of Smith and all his works:

Q. As a matter of fact, Dr. Smith is one of the greatest living authorities on the subject, is he not?

A. Oh, yes.

Q. And this book of his is used as a classic text in many universities and in several countries?

A. I believe so.

Understandably, now, from the

jury's point of view, your testimony is going to have to be consistent with Smith's opinion—or else. Hence the next question:

Q. Now, Doctor, I read from Smith: "Positive findings of fractured coccyx in women who have had children do not always indicate a recent fracture. Delivery may cause such fracture." Is that a sound medical statement—yes or no?

At this point, you're becoming irritated. Of course you agree with Smith's general proposition. Yet your own findings have convinced you that it doesn't apply to this particular case. So you hesitate to give the literally correct answer ("yes") for fear of misleading the jury.

That's a strong tendency in informed and intelligent witnesses. Cross-examiners hope for it and bank on it. Actually, the best thing to do in such cases *is* to give the literally correct answer—even if the question itself is illogical, incomplete, or distorting.

Leave it to the lawyer who called you to the stand to expose the distortion later on, when he questions you again. He will invite you to give a full explanation at that time.

But when being questioned by the *opposing* lawyer, you will avoid pitfalls only by strict attention to the content of the question at hand —without regard to the implications of your answer on the case as a whole.

Thus, if you're asked whether delivery isn't a *possible* cause of fractured coccyx, the only accurate medical answer is "yes." This holds even though you are aware that this answer seems unfairly to cast doubt on the opinion you've already expressed on etiology.

Of course, if you have the chance, you may by a phrase or even an intonation suggest: "It is a *possibility*, but in this case I exclude it."

All this sounds elementary; but the most fertile cause of trouble for intelligent witnesses under cross-examination is the urge to shape each answer to support their general position. The dull and unimaginative witness is for that very reason often more difficult to cross-examine effectively. He's too busy concentrating on the single question to worry about the effect of his answer on the case as a whole.

With that in mind, the doctor in the witness box is more cautious

when the cross-examiner shifts his attention to the question of disability, another important ingredient:

Q. You say she is disabled?
A. Yes.
Q. She can't work?

This latter question calls for conservative evaluation of disability in terms of occupation, function, social life, and such. Perhaps this:

A. I didn't say she couldn't work. I said she couldn't do the work for which she is skilled. I have no doubt that she can work at a job that doesn't involve protracted sitting, walking, driving, or other activity that causes pressure upon or jarring to the tip of the spine—if there be such a job.

That type of answer is jolting to a cross-examiner. It will probably result in a change of the subject. The attorney may then move on to the issue of permanency:

Q. You say the condition is permanent?
A. Yes.
Q. Medically speaking, you don't call a condition permanent if there's an efficient cure for it?
A. True.
Q. Isn't it a fact that a coccygectomy is often done in such cases and ordinarily leads to complete relief from pain?
A. Yes.

HANDITIP

Patient Pleaser

A real morale booster for the convalescent patient, I've found, is to give him a temperature chart to keep up. Result: keener awareness of his progress, goodwill toward his doctor for this evidence of interest in him. —LYON STEINE, M.D.

Q. Did you suggest such surgical treatment for this woman?
A. No.

This illustrates the effectiveness of the literally correct answer. The cross-examiner is unlikely to ask you at this point why you didn't suggest surgery. The terseness and assurance of your reply, in the face of apparent inconsistency, suggests to him that you have a very good reason. The jury will sense that too.

Moreover, they'll be curious as to what your reason is. This heightens the excellent effect of your testimony when, later on, you explain your reasons in response to further questions by the attorney who called you.

Where your diagnosis is unsupported by any objective findings, you can anticipate questions along these lines:

Q. You say she has a post-concussion syndrome? . . .
Q. And there wasn't a single ob-

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Can that "Sore Throat" patient get BOTH? . . . . .

THE DOUBLE-CLEANSING THERAPEUTIC GARGLE

Cēpacol is widely prescribed and recommended for:

- **Sore throat associated with the common cold and influenza**
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Alkaline, non-toxic . . . ideal for daily use as gargle or spray.

Yes!

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NOW AVAILABLE . . . Cēpacol Throat Lozenges! *These convenient, pleasant-tasting lozenges, dissolved slowly in mouth, provide a soothing, analgesic solution to relieve the dryness and irritation of sore throat.*

jective neurological sign that you could find? . . .

Q. In short, then, your diagnosis is based entirely on the fact that she *claims* she was unconscious for a short time after the accident and that she *claims* she experiences headaches, dizziness, and insomnia? . . .

Q. If she hadn't told you those things, you'd have no way of knowing? . . .

There is no use arguing with the lawyer about the validity of a diagnosis based on subjective symptoms. The best thing to do, in my judgment, is simply to answer "yes" to such questions—and to make the answer with unhesitant assurance, so as to give the jury a sense of your own confidence in the diagnosis.

It may be comforting for you to know that the doctor called *by the defense* in this case will be subjected to the same type of cross-examination in reverse. He's examined the woman and expressed the opinion there's nothing wrong with her that a monetary verdict won't cure. Then:

Q. Isn't it true, Doctor, that in medicine one may be suffering from an ailment, yet the cause can't be found on examination?

A. That occurs at times.

Q. Doctors frequently have to admit that they can't find the cause of their patients' ailments?

A. Yes.

Q. When you say that your tests on this woman were negative, you mean that you were unable to find the cause of the symptoms she complained about?

A. Yes.

Q. Is that sufficient reason for saying that the patient is not suffering at all?

A. I suppose not.

Somewhere in the attack on your testimony, the attorney is likely to ask for your records on the patient. If you haven't brought them to court, there will probably be a series of questions implying that you left them behind designedly—that there's something damaging in the record which you don't care to reveal.

It is better practice to bring your records. Besides, if you don't, the attorney may request you to return at a later date and the court may order you to do so.

When you produce the record, the opposing lawyer will examine it minutely. He'll probably ask whether you made any written reports to the attorney or to anyone else. If so, he'll call for these reports and go over them carefully.

Anything in those papers inconsistent with your testimony (or omitted from your testimony) or anything in your testimony but not in your record gives the lawyer leverage for cross-examination. It's wise, therefore, to examine all your records carefully before you testify.

—BERNARD R. LAUREN, LL.M.

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70 Ship Street, Providence 2, R. I.

1. Behrman, H. T., Combes, F. C., Bobroff, A., and Leviticus, R.: Ind. Med. & Surg. 18:512, 1949

The Newsvane

Plans Civil Defense Close to Home

Joe Stalin's aim may not be on Indianapolis yet, but the Indianapolis Medical Society is acting as if it were. First big hurdle in setting up its medical civil defense plan has been cleared with almost the entire 887 members volunteering for treatment-team duty. Among their program's novel features:

¶ M.D.'s are assigned to aid teams that will operate near their residencies, instead of near their offices. Explanation: "Doctors, being human, will rush to their homes when disaster strikes. This way, they'll be right where we want them."

¶ All citizens have been urged to get tetanus shots; local physicians have agreed to administer them at half-price.

Record Classes Milling About Medical Schools

"One thoroughly trained physician is worth two half-baked ones." That observation by Dean Joseph C. Hinsey of Cornell University Medical College is guiding most medical schools as they grapple with present king-size enrollments.

Medical colleges now have the largest freshman classes in history —a total of 7,187. That's 1,350 more freshmen than there were ten years ago according to Dean Stockton Kimball of the University of Buffalo's school of medicine. He calculates the effect is the same as if fifteen new medical schools had been opened.

"Medical schools today are training a total of 26,193 students," Dr. Kimball adds. "This is an increase of 1,090 more than last year and almost 5,000 more than were in training in medical schools ten years ago."

AMA Cautious About New Hospital Laws

Under the Hill-Burton Act, Uncle Sam has helped finance new hospital construction in rural areas. Now pending in Congress is legislation that would shift the emphasis to defense areas. But Dr. Walter B. Martin, speaking for the AMA, urges caution on any such change-over.

"We strongly urge the Congress *not* to authorize a new hospital construction program until it has been clearly shown that the Hill-Burton Act is inadequate to meet

the emergencies we foresee," he says. "This law has been very useful. Hospitals are being constructed in places where they are needed but where they probably would not have been built without Federal assistance. This has been, in our opinion, a good law."

He doesn't think so highly of the proposed new law (S. 349 and H.R. 1272). "It would give the [administering] agency sole authority, if cooperation of the local or state officials is not obtainable, to decide whether a hospital is needed by a community. If hospitals are constructed thus, wholly at the expense of the Federal Government, the community will expect the Government to maintain them after the emergency subsides. The Government would [then] be under constant pressure to extend its activities to provide medical services independent of local cooperation."

Dr. Martin also points out that new hospitals will set up new demands for more doctors. "To conserve our medical manpower," he concludes, "present facilities should be used to their utmost before new ones are constructed."

Three Most Popular Ways To Be Unprofessional

"Most violations of medical ethics are unintentional," says Theodore Wiprud, executive director of the District of Columbia medical society, after thirty years of watching M.D.'s try to toe the line on ethics.

He reports that the most common lapses are these three:

1. *Criticism.* Doctors sometimes forget the ethical ban on shooting off one's mouth about a colleague's ability or lack of it.

2. *Solicitation.* When he mails announcements of a new office location indiscriminately, a physician may make unethical inroads into a colleague's practice.

3. *Publicity.* Loyalty to a good cause may lure doctors into lending their names to certain advertisers and publicists—with results well known to all.

Hope Volunteers Will Keep Draft on Ice

If medical volunteers continue to step up at the present rate, a draft of doctors may not be necessary after all. No less an authority than Col. Richard H. Eanes, Selective Service's chief medical officer, has voiced this optimistic view.

"Now that we have the [draft] law," he says, "we would prefer that members of the profession arrange their own affairs and make induction unnecessary. We have every sign that this is the way it will work out."

Of the 83,316 physicians now registered with Selective Service, 12,356 are Priority I and Priority II men—either educated at Government expense or deferred for education during the last war. Nearly all these are expected to enter the service now, according to Colonel

Today's trend is to liquid

oral penicillin

"... it has been demonstrated repeatedly that the oral route is as effective as the parenteral route when adequate doses of penicillin are used."

Keefer, Chester S.: Am. J. Med. 7:216

Eskacillin 100
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The unusually palatable liquid penicillins for oral use

In keeping with today's trend to oral penicillin, S.K.F. now offers, for your convenience, Eskacillin in 2 strengths: 'Eskacillin 100', containing 100,000 units of penicillin per 5 cc. (one teaspoonful). 'Eskacillin 50', containing 50,000 units of penicillin per 5 cc. (one teaspoonful).

Among the many indications are:

- Acute sinusitis
- Bronchitis
- Tonsillitis
- Otitis media
- Pneumonia
- Cellulitis
- Gonorrhea
- Certain skin infections

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Eanes. If they do, it may save the Priority III and IV doctors—veterans and non-veterans up to age 50.

How about internes and residents in the Priority I and II classifications? "Local boards should continue to defer internes who are within their first twelve months of interneship," Colonel Eanes says. "We do not feel so strongly about residents." He points out that residents are so numerous—between 15,000 and 16,000—that even if all Priority I and II men were taken, only one of approximately eight residents would be hauled away from his civilian job.

"This may seem unreasonable to some who have hospital programs to maintain," he adds. "But you must not forget that the medical profession, although it tried, failed to solve the military physician problem. As a result of this failure, we have Public Law 779"—the doctor draft law he hopes won't be used.

Atomic Age Depreciates Human Life

Doctors are facing a new atomic-age idea of civil defense, in which human life is marked down to a bargain-basement low. If World War III comes, civilians will be as expendable as soldiers, according to the Bulletin of Atomic Scientists:

"The grim reality is that in case of a massive atomic attack, the main problem will be *not* how to save the greatest number of lives, but how to prevent the heartbeat of the nation from stopping . . . Not the death of millions, but the disorganization of industry and transportation will be the main threat. In the next war, civilian casualties will be considered in the same light as military casualties have been in past wars . . .

"Civil defense will be a part of the total war effort—a contribution to winning the war, not a means of keeping civilians safe from death, injury, or loss of property."

School Bell Rings for Industrial Medicine

"The most significant recent development in industrial medicine is in the educational end; we now have the beginnings of a formal training program," says Dr. Anthony J. Lanza, chairman of the AMA Council on Industrial Health.

The trouble, Dr. Lanza points out, is that "the program is now in a partial eclipse because of the war situation. Young men starting on medical careers are reluctant to sign up for available courses under present conditions."

Seven schools now offer industrial medicine courses, according to Dr. Lanza's count, but enrollment is still very low. One reason for this, apart from the military picture, is that the courses are fairly new and it takes time to build them up. [*Turn page*]

Michigan's course is supported by a grant of $1½ million from General Motors. Other schools giving industrial medicine include Harvard, Yale, Columbia, Pittsburgh, Cincinnati, and New York University.

The NYU course is perhaps typical. It runs for a year, offering nine months of didactic, lab, and clinical work; three months of in-plant training.

Pre-Med Training Gets Pushed Lopsided

Future physicians need a balanced education to save them from becoming science wizards but social nitwits. Starting with this belief, the Survey of Medical Education has sent out a subcommittee to scout through classrooms of about a hundred colleges that offer premedical training. Harry J. Carman, subcommittee director, summarizes his findings thus: "Only in a small minority of the institutions thus far visited is the premedical student obtaining a balanced education."

Mr. Carman finds four reasons for so many colleges offering a medically lopsided curriculum:

1. It never has occurred to them to do otherwise.

2. Premedical advisers are biology and chemistry professors, not really interested in non-science subjects.

3. Extra science courses help a student go into other careers if he fails to get into medical school.

4. Medical schools demand such heavy science preparation that college students don't have time for much else.

Is Blue Cross Coverage Getting Narrower?

The sirens are sounding about the policy in some hospitals of removing services from Blue Cross coverage and charging for them directly. It's not only dangerous, it's suicide, says Dr. George Baehr, medical director of New York City's broad-coverage Health Insurance Plan.

The HIP head is het up over how "the completeness of Blue Cross protection is being nibbled away by gradual elimination in some hospitals of certain essential services, such as anesthesia, X-ray, electrocardiograms, and transfusions. The chief effect of this scheme is to permit some of the doctors on the staff to increase their own personal incomes by extra charges to those who thought they had been paying for complete coverage."

He warns that the pruning of Blue Cross benefits is increasing the costs of hospitalization to the consumer. "If this trend is not curbed, it will finally reduce the benefits of Blue Cross insurance merely to bed and board and a minimum of nursing. It will eventually require the insured to pay separately for every kind of professional service required within a

A Proved Therapeutic Resource for the Control of Nausea and Vomiting of Gastrointestinal Origin

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EMETROL (Phosphorated Carbohydrate Solution) quickly inhibits the smooth-muscle contractions of the small intestine and the pars pylorica, involved in the vomiting mechanism.[1] A concomitant lowering of blood-sugar levels is believed to indicate that EMETROL helps restore the deranged carbohydrate metabolism often observed in emesis.

Clinical experience[2] in 243 cases of nausea and vomiting, including 172 cases of epidemic vomiting, 43 cases of regurgitation in infants, 17 cases of toxic vomiting, and 11 cases of motion sickness, has demonstrated the impressive efficacy of this novel therapeutic approach.

EMETROL presents balanced amounts of levulose and dextrose in coacting association with orthophosphoric acid, stabilized at a physiologically adjusted hydrogen-ion concentration. It appears to provide the proper chemical environment for reducing hypermotility of the gut and promoting zymogen activation.

FEATURES:

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- Nontoxic—no distressing side-effects
- Works quickly—often with a single dose
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- Simple regimen

supplied: Bottles of 3 fl.oz. and 16 fl.oz.

1. Bradley, J. E.: Address before the Clinical Session, A.M.A., Washington, Dec. 6, 1949.
2. Bradley, J. E.; et al.: J. Pediat. 38: 41 (Jan.) 1951.

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hospital. This will inevitably lead to the breakdown of voluntary insurance."

Adds Dr. Baehr: "It would be far wiser to adjust Blue Cross premiums so that hospitals can be reimbursed for the full cost of maintaining the services, than to permit the disintegration of comprehensive hospitalization insurance.

"In almost every institution students tell us they would like to broaden their formal education. But, in the face of the competition for admission to medical school, they do not dare omit the strongly recommended or even the recommended courses."

Leaner List, Poorer Pay For British M.D.'s

The pay-the-piper cutback in Britain's National Health Service is starting off with the doctors. "Operation Purge" is aimed at thinning down the patient list on which the NHS physician depends for his

Anecdotes

¶ MEDICAL ECONOMICS will pay $5-$10 for an acceptable description of the most exciting, amusing, amazing, or embarrassing incident that has occurred in your practice.

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Rutherford, N.J.

pay. His annual income is already less than one pound per head, on the basis of that list; but some heads are now likely to be cut.

This economy move is officially labeled "elimination of inflation in the records of persons on doctors' lists." It seeks to clean out all duplicate and dead entries by September. Six months of reducing may improve some figures, but British G.P.'s have raised no shouts of joy over what it's likely to do to the figures on their income checks.

Urges Closer Harmony On Hospital Staffs

House staffs and attending physicians have edged apart in recent years, it seems to Dr. Edward D. Spalding, an associate editor of the Detroit Medical News. They're going on opposite sides of the street instead of together, he believes.

What's wrong with the resident staff? They're apt to be too theoretical. "These young men have become preoccupied with passing their Boards, and have considered their hospital training just a further extension of their school years —a period of review, not advance. They have attempted to fortify their academic knowledge in all its minutiae, so that they can tell to the last decimal place the blood level of some eight-syllable steroid that might be asked them on a Board examination. In so doing, they have entirely lost sight of the fact that [the aim of] their training as residents [is] to apply the academic knowledge acquired in medical school to the study and treatment of the sick."

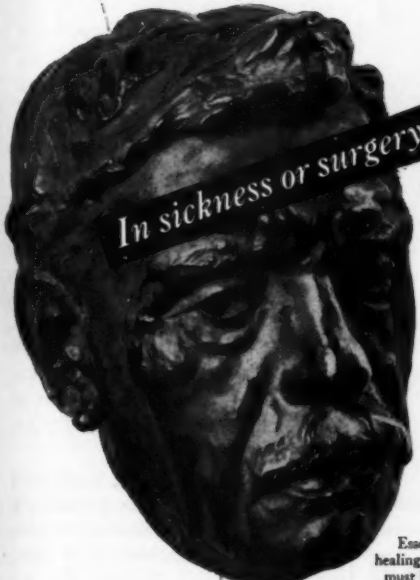
And the attending physicians are off on the other side; they're apt to be too practical. "A considerable number of staff men become so engrossed in making a comfortable living that they quite forget their Hippocratic duty to their younger colleagues in training. After all, it is still the direct responsibility of the attending staff to guide the further education of these younger men. All too often such a man, overly impressed with his own importance, fails to do his part as a preceptor."

Dr. Spalding wants to see the two groups arm in arm again. He puts it up to the attendings to bring this about. He lines up a two-point program for them:

1. "Take time to explain why and how things are done, on what ground a difficult decision is made, what are possible complications to be anticipated, and how they may be met."

2. "Delegate some authority to the young interne, who should be given a certain freedom of action in the handling of private patients. Gradually, with further training and maturity, more and more responsibility in case management can be given."

When the attending physician deals with the younger man in this way, Dr. Spalding promises, "the two become a team, each contrib-



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REFERENCES: 1. Coller, F. A. and DeWoose, M. S.: Preoperative and Postoperative Care, J.A.M.A., 141:641, 1949. 2. Jolliffe, N. and Smith, J. J.: Med. Clin. North America, 27:847, 1943. 3. Kruse, H. D.: Proc. Conf. Convalescent Care, New York Acad. Med., 1949.
4. Spies, T. D.: Med. Clin. North America, 27:273, 1943.

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uting a necessary part to a common purpose. The younger man learns to *apply* his academic knowledge . . . the practitioner secures willing and intelligent attention to detail in the management of his patients."

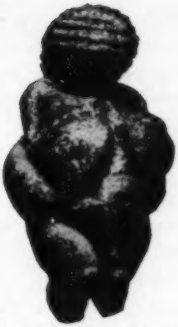
Cat-and-Dog Fight Over Research Animals

When a cautious physician prescribes a new drug, he often knows he's pinning his faith on a dog. Chances are, the drug was tried out on such animals to establish dosage. But antivivisectionists are now making it harder than ever to get enough dogs and cats for research experiments.

Laws to allow taking unclaimed pups and cats from city pounds are currently under discussion in Pennsylvania, Massachusetts, New York, Ohio, and South Dakota. But the antivivisectionists are loud in their protest.

The campaign in Pennsylvania has reached three-ring-circus proportions, with physicians acting as ringmasters. A doctor and three of his experimental dogs starred on a television show. The Pennsylvania medical society launched a letter-writing spree that showered mail on newspaper editors and legislators. Medical men have mounted public rostrums to enlist the support of women's organizations, kennel clubs, labor unions, health agencies, laboratories, and all medical groups.

The doctors' chief weapon has been a plump, orange-colored kit of



the Venus of Willendorf...

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This rotund prehistoric carving is unrefuted evidence that all through the ages mankind has been confronted by the dangerous and harassing problem of *obesity*.

Medical history has proved that hunger and appetite prohibit the obese patient from following prescribed dietary restrictions.

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AM PLUS—containing dextro-amphetamine sulfate, 11 minerals and trace elements, and 8 vitamins:

- Effectively curbs the appetite.
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Because of the sense of well-being, increased vigor and improved state of nutrition, the AM PLUS-treated patient is happier and in a *better* state of health at the end of the regimen.

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DEXTRO-AMPHETAMINE SULFATE	**5 mg.**		
CALCIUM	242 mg.	VITAMIN A	5000 U.S.P. Units
COBALT	0.1 mg.	VITAMIN D	400 U.S.P. Units
COPPER	1 mg.	THIAMINE HCl	2 mg.
IODINE	0.15 mg.	RIBOFLAVIN	2 mg.
IRON	3.33 mg.	PYRIDOXINE HCl	0.5 mg.
MANGANESE	33 mg.	NIACINAMIDE	20 mg.
MOLYBDENUM	0.2 mg.	ASCORBIC ACID	37.5 mg.
MAGNESIUM	2 mg.	PANTOTHENATE Ca	3 mg.
PHOSPHORUS	187 mg.		
POTASSIUM	1.7 mg.		
ZINC	0.4 mg.		

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facts showing the need for pound legislation. It includes campaign directions and a comic book for the children. In each community, a physician delivered the kit personally to his local newspaper editor. All doctors in each district signed a letter to accompany the kit to their representative in the Legislature. Medical men also arranged for science writers to visit experimental laboratories and to write stories that would scotch the old notion of a mad scientist torturing dumb animals.

In the midst of the campaign, a public opinion poll showed that opposition to the proposed pound legislation had dropped to 15 per cent of the people. There was a clear majority of 85 per cent on the side of science and the medical men.

Is the Doctor Draft Discriminatory?

Resentment at being uprooted from civilian life and clapped into khaki has been voiced by many hastily mobilized M.D.'s. One New Jersey physician recently charged that the doctor draft (Public Law 779) is discriminatory and is a means of regimenting medical men out of their freedom.

But this protest has been met head on by Dr. Aldrich C. Crowe, president of the New Jersey medical society. "Public Law 779 *is* discriminatory," he agrees. "We doctors enjoy considerable discrimination in our favor—any honest physician can list these for himself. Are

we to accept smugly all these perquisites but cry 'discrimination' when a cognate duty is imposed?"

We still have a free system of medical practice, Dr. Crowe points out. If it can meet the present emergency, that's a point in favor of freedom. But the emergency must be met. "People will not stand for being deprived of medical care for troops if, under our individualized system, every physician can decide to stay home when the going gets tough. This is our chance to show that under a free system we can police our own profession."

Backwoods Medical Care Not Backward Now

Country doctors don't have to kill themselves any more to be appreciated. Country patients can be taught the city custom of calling on their M.D. during office hours, instead of always calling him out for a home visit. The trick is to get them to build a community hospital, then build their medical habits around it.

Dr. George F. Bond of Bat Cave, N.C., cites his own community to prove this isn't just a doctor's dream. There are several scattered mountain settlements of about 6,000 total population in his bailiwick. They threw together a hospital with approximately no cash and about half that much credit. In a couple of years, the hospital has renovated the mountaineers' notions of medical care.

"Our people must learn that the

0.6 cc.=75 mg. (1 gr.) ferrous sulfate

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For iron deficiency anemia, medical authorities endorse pharmaceutical *iron and iron only*.

And ferrous sulfate in an acidulous vehicle is recognized as a most effective form of pharmaceutical iron.

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best medical care they can receive will be in the local medical center," says Dr. Bond. "Almost no one is too sick to be transported to these facilities. They must accept the fact that the days of long home calls, home deliveries, and home surgery are over, and that it is only through full utilization of the hospital they have built that these facilities will justify their existence.

"Finally, our country people must learn that it is within their power to kill their doctor by abuse of his time and by lack of consideration of his needs for rest and occasional recreation."

Dr. Bond's own Valley Clinic and Hospital—a converted schoolhouse—shows that he practices what he preaches. An outstanding feature of the little hospital's record is its number of out-patient visits: about 5,000 a year, in a community of 6,000.

Sister Kenny Shakes a Farewell Fist

American doctors take a tongue-lashing from Sister Elizabeth Kenny in an article called "Why I Left America." Writing in the Woman's Home Companion, she describes her fight against their "conservatism and hostility." She recalls "the objections, the obstructions, backbiting, and often the untruthful propaganda of skeptics and cynics—the blind critics who stubbornly refused to see the evidence laid before their very eyes."

But that isn't why she left this

A MAJOR RESPONSE

Veratrite, for routine use, is a reliable hypotensive agent without serious side-effects. Circulatory improvement, a gradual fall in blood pressure, and a new sense of well-being can be obtained without complicated dosage schedules or daily dosage adjustments. Economy—a point of importance in long-range therapy—is in favor of Veratrite in the management of the great majority of hypertensive patients.

Supplied: **Bottles of 100, 500, 1000 at prescription pharmacies everywhere.**

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Beginning Dose: 2 tabules t.i.d., after meals.

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country to return to her native Australia. "I feel the long fight is won," she says. "My work now has firm, permanent roots in America."

During her ten years in this country, Sister Kenny reports, she:

1. Treated about 7,000 infantile paralysis victims.

2. Wrote and published a book on her method.

3. Inspired a "documentary movie" on the subject.

4. Set up the Elizabeth Kenny Foundation to finance her work.

5. Set up two Elizabeth Kenny Institutes (in Minneapolis and Jersey City) for treating polio victims and training therapists.

She says she probably won't return. But she'll send back a weekly lecture by wire recording, for the traditional woman's last word.

Welcome-Mat Committee Helps DP Doctors

Medical men have been given a revealing glimpse of how displaced physicians from Europe get settled in this country. James Brunot has reported on the first six months' work of the National Committee for Resettlement of Displaced Professionals, of which he's executive director.

The committee's biggest surprise: Their job wasn't as tough as expected. There were only about 25 per cent as many applicants for resettlement as had been expected. "The number of DP physicians had shrunk from the [original] estimate of 2,300 to an undetermined num-

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ber in the neighborhood of 500 to 600," Mr. Brunot found.

Two main assumptions have guided the committee. One is that not all the refugee physicians entering this country are "qualified to assume full responsibility as members of the American medical profession." The second assumption is that best beginnings may be made in an institutional setting, where the new arrival may be kept under supervision. So the committee looks for openings on institution staffs instead of in private practice.

"A pilot project that we have tried in Connecticut," Mr. Brunot says, "points to a pattern that may be workable in a number of other areas. The committee was informed that a number of vacancies existed in the medical staffs of various state institutions. We were told that foreign physicians, if properly qualified, would be welcomed as candidates for certain positions classified as interneships.

"We worked out a simple procedure in referring candidates for consideration by Connecticut hospitals. From time to time, we receive dossiers summarizing the medical education and experience of physicians who have arrived or are about to arrive in the U.S. If these summaries indicate eligibility, they are passed on to the state hospital authorities, who select individual physicians with whom interviews are arranged.

"Thus far thirty-six records have been submitted and twenty-four cleared; twelve physicians already

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- Precision-fitted glass barrel and plunger.
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in this country have been interviewed. Three of these actually are at work in various state institutions, and three more are still under consideration. Twelve others will be interviewed as soon as they arrive in the U.S."

Students Need Pep Talk On Military Duty

Gone are the days when doctors jostled their way into military uniform. And Dr. James C. Sargent thinks it's time to do something about it. As chairman of the AMA Council on National Emergency Medical Service, he's ready to deal with the emergency.

"In World War I," he recalls, "doctors flocked to the colors under the inspiration of a widespread surge of public patriotism. The second war proved different. Patriotism still was pressing, but Procurement & Assignment more so.

"Then came this [new] threat of war. Volunteers were nil. Almost none among the reserves requested orders. Many—even the active reserves—sought cancellation when orders came. And now the draft."

Dr. Sargent calls for "an honest and forthright effort to see that military medicine returns to better grace with the doctors of the land." The place to start that effort is the medical schools, he holds: "Our students should be taught the likelihood that they must serve their country some time during their careers . . . Whether or not we are entering an era of compulsory mili-

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Tolanate, making available for clinical use the therapeutic virtues of inositol hexanitrate, finds wide usefulness in the management of hypertension. It has been shown to be particularly valuable in essential hypertension and the hypertension of the menopause. One of its most desirable clinical features is the complete absence of "nitrite headache," expanding its applicability to many patients who cannot tolerate other organic nitrates.

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PROMPT SUBJECTIVE RELIEF The distressing subjective symptoms of hypertension are promptly relieved by Tolanate. The general vasodilation resulting from the relaxation of the arteriolar smooth musculature aids in improving tissue nutrition and function.

PROLONGED SUSTAINED ACTION Inositol hexanitrate, the active ingredient of Tolanate, is one of the longest-acting organic nitrates known. Hence, administration every 4 to 6 hours maintains a uniform depression of the blood pressure.

Tolanate is supplied in 10 mg. tablets in bottles of 100 and 1,000. Also available as Tolanate with Phenobarbital, each tablet containing 10 mg. of inositol hexanitrate and 16 mg. (¼ gr.) of phenobarbital.

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tary service, the unsettled world situation and the simple fact that doctors are essential to our military organization justify some special effort being made to interest medical students in military medicine.

"No one can persuade me that the surprising reticence of our ASTP and V-12 boys to come forward when their country called was anything but clear evidence of failure on the part of those of us responsible for their education. Now would be a good time to plan against similar failure in the future."

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No more need for you to ogle cruise literature and yearn to travel beyond the limits of your bank account. There's a search on for medical men ready to weigh anchor for three-month voyages. Their itinerary will be a round trip from New York to ports of call in Europe and other continents.

They don't pay for passage; they get paid. All they need is U.S. citizenship, medical education and interneship at approved institutions, a state license to practice medicine, and luggage packed to sail on short notice.

M.D.'s meeting these specifications can get civilian positions as ship doctors on Navy transports carrying European refugees to their respective promised lands. These posts may be had on the paying-vacation basis, for one 90-

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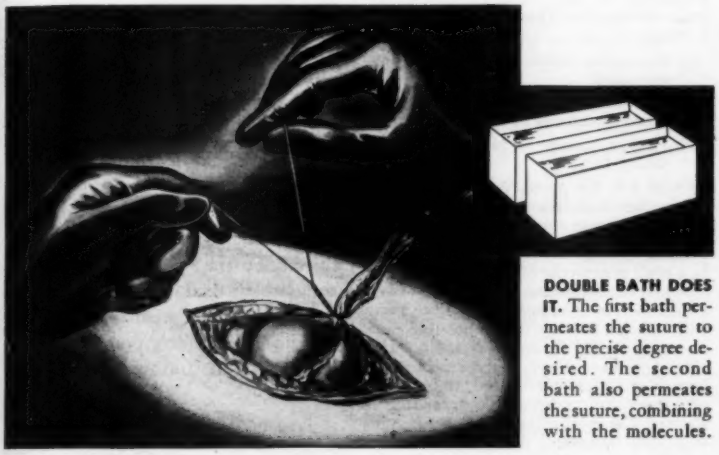
gives a suture absorption rate you can count on



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M.D.'s Seek to Make Asia Healthier, Friendlier

Twenty physicians are among the fifty new public health recruits being sent into the battle for Asia at the request of the Economic Cooperation Administration. They'll try to balance the Korean war on the north by a life-saving campaign to win friends and influence Asians in the south. More specifically, they'll help deal out the ECA's $16 million worth of health and sanitation to 136 million people in Burma, Thailand, Indo-China, and Indonesia.

Eighteen consultants have already hopped over to the ECA front on Asia's southeastern fringe. Twelve are now packing for the same mission. The fifty new appointees will bone up briefly at the Harvard School of Public Health before heading out for one- and two-year stretches in the Far East.

Riding the Range With The Quack Patrol

Cancer these days is the ripest field for quacks. Just as fear of tuberculosis fifty years ago encouraged fakers to peddle "consumption

NATURAL CORRECTIVE

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NEO-CULTOL provides a natural, physiologic corrective for patients troubled with chronic constipation not due to an organic process. It acts gently, restoring the normal intestinal flora, counteracting intestinal putrefaction, and establishing normal colonic function.

NEO-CULTOL does not depend upon cathartic action. It supplies a viable implant of *Lactobacillus acidophilus* in a highly refined, tasteless mineral oil jelly, providing gentle lubrication without griping, flatulence, or diarrheic movements.

FEATURES: • Pleasantly chocolate flavored, ensuring palatability • Melting point adjusted to prevent leakage • Non-habit-forming.

DOSAGE: Adults — 1 or 2 teaspoonfuls. Children — 1 teaspoonful.

IMPORTANT: To be taken only at bedtime.

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cures," now the sure-cure operators are riding high on today's cancer fears. The AMA Bureau of Investigation, which keeps track of such frauds, reports that it gets more queries about alleged cancer cures than anything else.

The fattest file in the bureau's cancer-fake record drawer is that of Dr. William F. Koch, who at one time operated around Detroit. In 1919, a few months after acquiring a genuine M.D. degree, he announced himself ready to eradicate cancer with a synthetic antitoxin. One of his first disciples was a minister named Rueskamp, who preached the virtues of the Koch cure until his untimely death—of cancer.

A grateful family of "cured" cancer sufferers, the Wahls, helped Dr. Koch keep his cancer cure in the news. Albert L. Wahl wrote a book describing his sister's recovery under the Koch treatment. But before he was able to convince the medical profession, he died of leukemia. A couple of months ago, the "cured" sister's death certificate was filled in. Contributory cause of death: metastatic sarcoma.

Without too much publicity Dr. Koch has skipped to South America. But his cancer cure lingers on, supported by a surviving member of the Wahl family and other devotees.

Another active file in the AMA Bureau of Investigation is that of Harry Hoxsey of Dallas. Although not a doctor of medicine, he con-

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"My doctor recommended it"

THERE ARE *several hundred* different brands of evaporated milk... but, for infant feeding, Carnation is the one prescribed by many of America's leading doctors and hospitals. Here are four outstanding reasons why Carnation has won the trust of the medical profession:

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For years, champion cattle from Carnation Farm have been distributed to dairy farmers all over the country, thus improving the local milk supply to Carnation plants.

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Carnation Field Men regularly check herds, sanitary conditions of the farm, and equipment. Milk is rejected if it fails to meet any of Carnation's high standards.

3. Carnation Processes ALL the Milk Sold Under the Carnation Label

From cow to can, Carnation Milk is constantly under Carnation's *own* continuous control. It is processed in Carnation's *own* plants with "prescription accuracy" to insure complete uniformity. Carnation never has—and never will—sell milk processed by another company.

4. Carnation Quality Control Continues Even AFTER the Milk Leaves the Plant

Every can bears a code number...so Carnation representatives can check stocks *after* they're shipped, to be sure mothers and hospitals receive fresh, high-quality milk.

No other evaporated milk goes to greater lengths to protect the doctor's recommendation. No other form of whole milk is safer or more nourishing for babies. So Carnation is the milk you can specify—by name—with confidence.

Don't say "Evaporated Milk"
—say CARNATION
"The Milk Every Doctor Knows"

"from contented cows"

cocted a powder, a salve, and a elixir, which he prescribes to clear up cancer. In a recent court case he managed to convince a Federal Judge of the value of his treatments. But the AMA bureau is keeping an eye peeled in his direction.

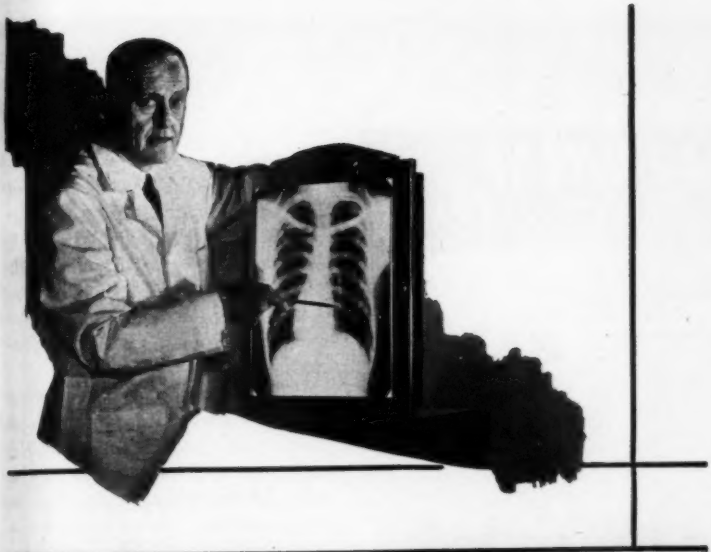
Also on the bureau's list is the name of Arthur Osborne Phillips. After a career in California that was the subject of considerable investigation, he showed up in Kansas with an assumed M.D. An accident there gave him occasion to sue for damages; he filed a claim for the loss of his medical practice. AMA records showed that his most recent institutional training had been at Leavenworth Penitentiary.

The bureau reports many recent queries about the medical background of Dr. Gayelord Hauser, author of several popular books on diet. His title is not based on an M.D. degree. He has a naturopath's license in Florida and a chiropractor's license in Nevada.

Senator Draws Fuzzy Line On Socialized Medicine

A double dose of definitions has been poured out by Senator Theodore F. Green (D., R.I.). And he asks the AMA to join his constituents in gulping it down. Recently he answered a question from a local PTA council by defining what socialized medicine is and isn't.

What he says it *is*: "Socialized medicine is a system of care whereby doctors, dentists, nurses, and



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THROUGH CHEMISTRY

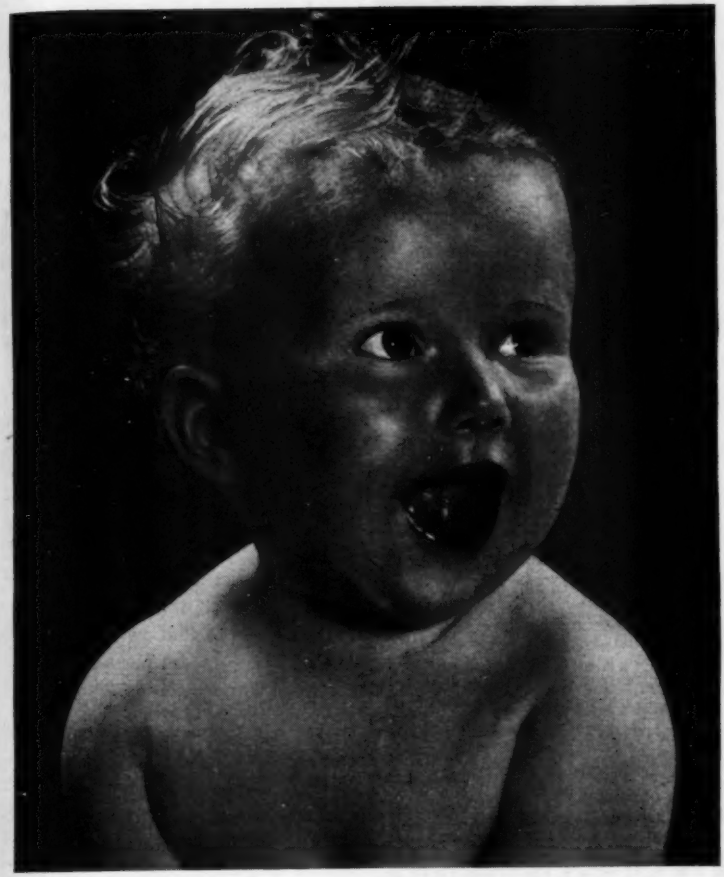
other medical personnel work as salaried government employes, and whereby all hospitals are government property. Under this system, the whole program is paid for out of general tax revenues. This is socialized medicine. At the present time, it is practiced in only one large nation—the Soviet Union. It is repugnant to most Americans. It is vigorously opposed, not only by the medical profession, but also by President Truman and the Democratic Party."

What he says it *isn't*: "President Truman's proposal for national health insurance is not socialized medicine, and the officials of the AMA know it is not socialized medicine . . . I am opposed to any deliberate effort to confuse the American people by telling them that [it] *is* socialized medicine."

Trying to prove that the AMA has put the label on the wrong bottle, he continues: "National health insurance would not interfere with the patient's free choice of his doctor. Neither would it interfere with the doctor's free choice of his patients . . . This is a proposal which does not in any way interfere with the traditional relationship between doctor and patient."

Worm's-Eye View of the Cause of Croup

The face is familiar to every doctor—that of the patient who dopes out her own diagnosis—but the diagnosis is brand-new. Here is the



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letter just as it was received by Dr. R. R. Goad of Muscatine, Iowa:

"Our baby was not improving after we brought him home from the hospital. The croupy condition persisted. Each night the croup increased and the spasms came oftener.

"I was desperate, so one night I gave him one of Field's worm powders. He went to sleep and rested fairly well. The next morning I gave him another and repeated the dose the next night and morning, following that with a big dose of castor oil. That brought the worms before they were completely digested. Since then his sleep has been wonderful. He certainly had plenty of worms.

"Now, doesn't it seem to you that the croupy cough comes from a wormy condition in the child? Several things make it seem so to me. Isn't it possible that when a child is taking a cold, he refuses to eat enough food to satisfy the parasites? And then, while the child sleeps, they come up into the throat and chew the larynx, causing croup and those spasms of choking? Ice packs on the throat will give almost instant relief, because the worm doesn't enjoy the cold and hurries back down where the temperature is more comfortable. But when the throat is warm, they come up again and chew.

"I would certainly like to have this tested out to see if all croupy children do not have worms. Would appreciate your opinion on this."

Often it takes just this help when a patient should give up coffee!

You know from experience that patients break the coffee habit more easily—have less tendency to "backslide" when you recommend *caffein-free* Postum instead.

Now, you can help your patients who should give up coffee, in an even more tangible way... by actually giving them a generous trial supply of Postum, with your compliments. Simply use the coupon below—and we will gladly send you, without charge or obligation, our special Professional pack of 12 trial-size packages of Instant Postum. The handy order blank below is for your convenience.

* * *

While many people can drink coffee or tea without ill-effect—for others, even one to two cups may result in indigestion, hypertension and sleepless nights. *See "Caffein and Peptic Ulcer" by Drs. J. A. Roth, A. C. Ivy, and A. J. Atkinson —A. M. A. Journal, Nov. 25, 1944.*

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SUBJECT INDEX TO

Medical Economics

OCTOBER 1950—MARCH 1951

No articles of less than page length are included. Back copies, when available, may be purchased for the established back-copy price of 25 cents each. The following listings show article title, month of issue, and page number.

Memo from the Publisher

● One of the first political-type cartoons we ever published showed a small, unattractively-clad girl labeled "Federal Sickness Tax." Over her head two politicians were craftily slipping a good-looking new dress labeled "National Health Insurance."

After a lapse of several years, we recently revived this type of cartoon feature. The experiment is neither common nor easy, since abstract ideas in the realm of medical economics are seldom simple to illustrate. But you might like to hear how we try.

Each month our editors pick out a topic that seems of major current interest (last month, for example, the financial plight of the medical schools). Then they pool their ideas on what the *point* of the cartoon ought to be. In this case, our staffers decided the drawing should convey (1) the potential danger of Federal aid, and (2) how private physicians could avert that danger.

Our departmental artist takes it from there. He is Daniel Dowling, political cartoonist for the New York Herald Tribune Syndicate, and an established name in the business. Mr. Dowling delves into his private storehouse of cartoon settings and characters, then mails us a rough sketch of what he has in mind.

Last month our editors' ideas emerged as an old-fashioned melodrama scene: the villain ("Federal Control") offering to buy up the mortgage ("Medical School Deficits") while casting a covetous eye toward the daughter of the house ("Academic Freedom"). Offstage stands the hero, representing private M.D.'s, his arms laden with small money-bags. Caption: "Your Cue, Doctor."

Thus an idea that's hard to describe in words (as witness the above) is reduced through the cartoonist's art to simpler, more memorable terms. Our editors may suggest minor changes in labels or the positioning of characters, but the finished drawing is strictly Mr. Dowling's own.

We think he has done an interesting job of presenting such basically unphotogenic ideas as the effect of fee-gouging, the importance of catastrophic coverage, the need for more grievance committees. Take a look at page 62, this issue—or a comparable page in any subsequent issue—and judge the finished product for yourself.

—LANSING CHAPMAN

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No. 3: "Instructions for Bathing Your Baby."
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No. 5: "Home Care of the Bedfast Patient."